United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

Dates of Onsite Review: December 3 – December 7, 2012

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICFMR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

Methodology

In order to assess the facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of the review, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for offsite review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while onsite. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(c) **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Interdisciplinary Team (IDT) meetings, discipline meetings, incident management meetings, and shift change.

(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the facility.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.
g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at SGSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The facility director, Charles Njemanze, set the tone for the week and was supportive of the monitoring team's activities. He was readily available to the monitoring team. The Settlement Agreement Coordinator, Misty Mendez, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed. She was extremely organized and efficient.

Second, management, clinical, and direct care professionals continued to be eager to learn and to improve upon what they did each day to support the individuals at SGSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite review. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist SGSSLC in meeting the many requirements of the Settlement Agreement.

Third, a brief summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and a full understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

<u>Restraint</u>

- The facility made very good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention.
- There were 485 restraints used for crisis intervention between 6/1/12 and 11/30/12 involving 34 individuals. This was a considerable decrease compared to the 623 restraints for crisis intervention reported the previous six months.
- There were 42 instances of dental/medical pretreatment sedation from 4/1/12 through 9/30/12. This list included both pretreatment sedation prior to medical appointments and mechanical restraints (mittens) used to promote healing. The facility reported that no individuals received pretreatment sedation prior to dental procedures.
- Action taken by the facility to address compliance with section C since the last monitoring visit included:
    - Informed Trauma Care training and consultation was provided to the psychologists.
    - Crisis Intervention Plans were developed for some individuals.
    - The restraint database was updated. Information regarding restraint trends was distributed to each home.

    - A restraint reduction coordinator was hired.
- A tool was developed to interview DSPs on their knowledge of restraint prevention strategies. One DSP was being interviewed daily by administrative staff.

Abuse, Neglect, and Incident Management

- The facility had made substantial progress in addressing compliance with most items of provision D, but had made little progress in addressing factors contributing to the large number of incidents and injuries at the facility.
- DFPS confirmed 13 cases of physical abuse and 22 cases of neglect. This was from a total of 491 allegations since April 2012 that included 162 allegations of physical abuse, 46 allegations of verbal/emotional abuse, 3 allegations of exploitation, and 117 allegations of neglect. An additional 60 other serious incidents were investigated by the facility.
- There were a total of 2133 injuries reported between 4/1/12 and 9/30/12. These included 30 serious injuries resulting in fractures or sutures. Many of the serious injuries were preceded by similar incidents, not adequately addressed.
- To move forward, the incident management department should take an integral role at the facility in looking at both systemic issues that contribute to incidents and individualized supports and services that place individuals at risk.

Quality Assurance

- There was good steady progress. The QA plan narrative was improved since the last review, though some further editing and additional detail were needed. The QA data list/inventory continued to improve. The QA department should now ensure that all important types of data (i.e., key indicators) are included in the data list/inventory.
- The monthly benchmark meetings continued, during which the QA director and SAC met with the section leader to review a variety of QA and Settlement Agreement related activities.
- The QA director now required each section leader to provide an analysis of the data, not just a description of the data. The QA director should now create a way of determining whether the section leader's analysis was of sufficient quality and adequacy. The QA report had improved in a number of ways, such as the inclusion of the last three months of data followed by a longer trended line graph for some of the data elements.
- The QI Council meeting observed by the monitoring team was organized, and participation was better than during the last onsite review. The facility director frequently participated.
- The QA director continued to improve the CAPs system. It appeared, however, that CAPs were not yet identified for all areas of services and supports. Not all CAPs, however, were implemented fully and in a timely manner and many were not modified when needed.

Integrated Protections, Services, Treatment, and Support

- The ISP planning and development processes had been revised and reflected in new policy. SGSSLC QDDPs and many team members had been provided training on the new process by statewide consultants.
- The first IDT meeting held in the new format was during the week of the monitoring visit. Thus, the new ISP process had not yet been completed for any individuals at SGSSLC. Since there were no written ISPs available that were representative of the new ISP process, this review was limited to data gathered through the facility's self-assessment process and limited observation of the new process.
- There had been some positive steps forward with the new ISP process.
    - Two IDTs received training on the new ISP and integrated risk process from DADs consultants.
    - A mentoring program was implemented using department heads from various disciplines to attend ISP meetings and provide feedback to the IDTs on implementation of the new ISP process.
    - A new QDDP Educator was hired.
    - A new department had been established to write and train staff on all skill acquisition plans.
- The monitoring team observed two annual ISP meetings in the new format. The IDTs followed the format of the new ISP process and team members held a more integrated discussion. Team meetings, however, were very lengthy and the IDTs were struggling with how to integrate the risk discussion into the ISP meeting.

Integrated Clinical Services

- The facility made some progress in this area. Provisions G and H had been united with much of the emphasis for this review placed on Provision H. A single policy was developed for both provisions, but the policy clearly focused on section H. The medical administrative director served as the lead for this section G as well as section L. With the many tasks related to reorganizing the medical department, a singular focus on this provision would not be expected.
- The monitoring team met with the medical administrative director and QA nurse to discuss the facility's continued efforts in integrating clinical services. The monitoring team learned that a great deal of collaboration occurred between the section G and H leads and the medical compliance nurse in the development of the facility's policy.
- Throughout the week of the review, the monitoring team encountered examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

Minimum Common Elements of Clinical Care

- The progress seen in this section was also a lesson on how a section or project can gain momentum when placed under the direction of the appropriate individual. The center's lead should be commended for the work done in this provision. A comprehensive policy was developed to guide these efforts.
- The section H lead used the presentation book and November 2012 report to explain the status of section H. She explained that the facility proceeded with this provision by defining the core clinical services: communication,

habilitation, physical and nutrition management, nursing, medical, psychiatry, dental, pharmacy, and psychology. Each clinical discipline was responsible for conducting required audits and reflecting that information within their departmental data summaries that were submitted for the QA Benchmark Meetings. An audit tool was developed for each clinical service to validate that the required services were provided, monitored, and documented within the data summaries.

- Thus, for each provision item, each discipline was expected to address the requirements of the provision, monitor the services, and provide documentation that this was done. This was achieved to variable degrees of success for the different departments.

At-Risk Individuals

- Progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, however, adequate plans were not yet in place to address all risks identified.
- Consultants from state office recently provided training to select department heads and IDTs. Two IDTs had been trained on the new process. The monitoring team had a chance to observe both teams hold meetings utilizing the new format. Team meetings were very lengthy and the IDTs were struggling with how to integrate the risk discussion into the ISP meeting. Facility wide training on the new risk process was scheduled for January 2013.
- Several key department heads were working together to ensure implementation of the new process. The newly created ISP mentoring team members were evaluating progress with section I requirements using the ISP monitoring tool.
- Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs.

Psychiatric Care and Services

- SGSSLC provided psychiatric services by qualified physicians. With the previous vacancy, the maintenance of any integration beyond what could be accomplished in psychiatry clinic was delegated to the two psychiatric nurses and the psychiatric assistant.
- The psychiatrists displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation.
- Psychiatric clinic included representatives from multiple disciplines. This was beneficial, given that psychiatrists were not generally available to attend ISP meetings.
- There were an inadequate number of psychiatric assessments completed and this affected the quality of the diagnostics and justification for treatment with medication. The psychiatry department's data collection regarding the

Reiss screen illustrated that 65% of the newly admitted individuals received a Reiss screen and, of these, only 47% were completed within 30 days of the admission date.

- The polypharmacy committee inappropriately summarized the psychotropic aggregate data because even medications solely utilized for the management of a seizure disorder were included in the psychoactive count. The facility continued to struggle in the area of informed consent. Psychology department was responsible for documentation, however, the psychiatrists were receptive to being responsible for this medical duty.

Psychological Care and Services

- There was continued progress and several improvements since the last onsite review. These included the development of data collection reliability, improvements in the comprehensiveness of the progress notes, and more databased decisions in interdisciplinary meetings. There was an increase in the percentage of functional assessments for individuals with PBSPs, improvement in the comprehensiveness of the functional assessments, an increase in the percentage of individuals with annual psychological updates, and recent development of a method for the collection of treatment integrity.
- Further work was necessary to ensure that replacement/alternative behaviors are collected and graphed for each individual with a PBSP. The facility will need to establish minimal frequencies of data collection reliability and minimal acceptable data collection reliability levels, and demonstrate that those levels are achieved. Other areas are to increase the number of individuals with functional assessments and the number of individuals with annual psychological assessments. There is a need to establish minimal frequencies of treatment integrity and acceptable treatment integrity levels, and to demonstrate that those levels are achieved.

Medical Care

- Much of the progress was seen in the revision of systems, how services would be delivered, and progress monitored. Information was utilized in an ongoing manner to improve compliance with preventive care screenings. Required assessments were tracked and formats revised to comply with the Settlement Agreement requirements. The daily medical provider meeting continued and the topics expanded.
- Individuals received basic medical services, such as immunizations, vision, and hearing screenings. There were small increases in the rates of most cancer screenings. The long-term medical staff knew the individuals very well and demonstrated genuine concern about their well being.
- Problems were noted in follow-up of acute issues, overuse of verbal orders, lack of monitoring for the use of psychotropic agents, and the inappropriate use of standard operating procedures to provide medical treatment. IPN entries were generally written in SOAP format and overall the quality of the documentation had improved.
- External and internal medical audits were conducted. Medical management audits were also conducted. Corrective action plans were implemented for both. The medical audits remained focused on processes with no assessment of the

clinical outcomes for individuals. The mortality system continued to lack a reliable means of resolving problems that were discovered in the various reviews.

Nursing Care

- There were significant and positive changes occurring in the Nursing Department, including completing nursing assessments in a timely way, reducing nurses' unscheduled absences and late arrivals to work, completing nursing assessments of pain when individuals suffered injuries/illness, and improving the storage and administration of individuals' medications.
- Further, the facility and the Enteral PIT were finally able to show that, as a result of training, monitoring, and supervision, significant and sustained improvements in nurses' safe and accountable administration of enteral nutrition and fluids were made.
- There was little to no progress made in improving the content and quality of nursing assessments and plans. The facility had not developed and implemented a skin integrity program. The facility's infection prevention and control program was still not where it needed to be. Nursing education initiatives were not complete. Emergency medical equipment was still not being regularly checked to ensure that all equipment was present, available, and in working order.
- There were more vacancies in the Nursing Department than there were six months ago.

Pharmacy Services and Safe Medication Practices

- There was no demonstrable progress towards substantial compliance in this area. Many of the problems noted during the June 2012 review had not only persisted, but in many instances had worsened. Few, if any, areas showed slight improvement.
- The pharmacy staff was not receptive to feedback provided by the monitoring team. Furthermore, there was a reluctance to accept accountability for problems.
- There was relatively little documentation of communication between the pharmacists and providers given the number of medications prescribed and dispensed. The pharmacy department continued the practice of not reporting prescribing errors even though this was required by state policy and the requirement was highlighted in the June 2012 report.
- Completion of QDRRs remained a challenge for the facility. Data submitted by the facility indicated that 70% of individuals did not have current QDRRs as of 12/7/12.
- There was essentially no ADR reporting since the last compliance review. Training was reported to be ongoing, but the monitoring team found the content of the training to be less than adequate. DUEs were completed, but were not presented to the Pharmacy and Therapeutics Committee in a timely manner resulting in a delay of corrective actions.

- The facility reported medication variances, but continued to struggle with having a comprehensive program in which all disciplines worked cooperatively to improve the system.

Physical and Nutritional Management

- Progress was made towards substantial compliance. The PNMT was fully staffed. They had completed a number of assessments in a timely manner. The two most current ones showed significant improvement.
- The facility must effectively track individuals with key health issues in order to watch for facility-wide trends. Individuals who require PNMT referral may be more effectively identified and in a timely manner.
- The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They routinely tracked their status in an organized manner with clearly stated outcomes and exit criteria. Follow-up of individuals for whom they provided assessment/review of was consistent and well documented.
- Mealtimes and position and alignment were improved, though some issues related to the organization and efficiency of the dining rooms were evident. There was very limited space and home staff were responsible to plate and serve the meals.
- Monitoring of staff compliance must be consistent and effective. If staff have demonstrated competency, there must be an expectation that the plan be implemented as written every time.

Physical and Occupational Therapy

- There was continued progress with this provision. Staffing continued to be a concern, and as a result, therapists had to make choices between participating in ISPs and ISPAs or completing assessments and updates in a timely manner for the IDTs to have for these ISPs.
- A system of assessment audits successfully shaped the consistency of content in the assessments and updates completed by the therapists.
- Routine effectiveness monitoring was conducted by the clinicians. Staff compliance monitoring by the PNMPCs was deemed to be inaccurate. Therapists need to routinely observe the implementation of strategies and ensure that staff are able to correctly integrate supports throughout the day.

Dental Services

- The dental clinic made visible progress since the last compliance review. The new dental director was very engaged in the processes and activities of the clinic and facility.
- All individuals were essentially being comprehensively reassessed and treatment plans developed. One particular psychologist was reported to have become more involved in clinic, helping to assess the needs of individuals. The method for rating oral hygiene was changed to a more objective system and individuals with poor ratings were enrolled

in a toothbrushing program. The compliance rate with annual assessment overall improved with the exception of October 2012. IPN documentation was now generated electronically resolving the legibility problems noted in previous reviews.

- The average failure rate was 22% with a refusal rate of 5%. However, the monitoring team had concerns about the accuracy of the refusal rate and the classification of failed appointments.

Communication

- There was continued progress with this provision. The therapists implemented many very excellent programs and the completed assessments were significantly improved. Progress with the completion of all needed assessments continued to be an issue. The assessments that were completed were significantly improved and the system of audits was effective in raising the quality and consistency of these.
- Documentation related to therapeutic interventions must be tightened up with clear rationale for initiation and termination and with consistent reporting of progress toward measurable objectives.
- More work was needed in the development of SAPs for PBSP replacement behaviors and coordination with psychology department regarding the many individuals whose challenging behaviors were related to communication and language problems.
- A system of effectiveness monitoring had been implemented. This system appeared to be effective to identify issues related to communication supports.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were some improvements since the last review. These included an increase in the percentage of SAPs reviewed that contained a rationale for its selection, an increase in the percentage of SAPs reviewed that contained an acceptable plan for generalization, and the initiation of SAP integrity measures.
- A number of actions were recently taken or initiated, such as the establishment of the Program Resources department which consisted of staff exclusively dedicated to the development and implementation of skill acquisition plans, an activity engagement PIT to improve individual engagement and participation in day programming, and the training of direct care professionals (DCPs) in the implementation of SAPs.
- Much work is needed to track engagement across all treatment areas, review trends, and establish acceptable levels of engagement in each treatment area; to document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans; and to ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data. The facility staff will need to track SAP integrity measures, establish minimal frequencies of integrity measures, establish minimal acceptable treatment integrity levels, and demonstrate that those frequencies and levels are achieved. Finally, they will also need to establish

acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved.

Most Integrated Setting Practices

- SGSSLC continued to make progress across all of section T. The specific numbers of individuals who were placed and who were in the referral and placement process had increased to 16% of the total census. Approximately 10% of the individuals at the facility were on the active referral list.
- 18 individuals were placed in the community since the last onsite review. Unfortunately, of these, 3 individuals had severe problems in the community and had already returned to the facility. The placements of 2 others were reported to be unstable and a return to the facility likely. A total of 4 individuals were returned to the facility after community placement, and a fifth was expected in the week following the onsite review.
- Of the 20 individuals who received post move monitoring, 12 (60%) were maintaining successfully or fairly successfully in the community. Of these 12, however, 5 had serious events occur during their first 90 days in the community. Thus, of the 20, only 7 (35%) had transitions that went as the IDT, for the most part, expected.
- Of the other 8 individuals (40%) who received post move monitoring, 4 had returned readmitted to the facility, 2 were likely to soon return to the facility, and the other two remained unstable in their placement. More should be done when supports are not implemented, not implemented correctly, and/or if there are problems in the placement.
- Some new activities were occurring regarding placement and transition: the plan for creation of a transition home, initiation of a most integrated setting practices workgroup, and a regular monthly meeting of the APC and his staff.
- Changes to improve the quality of the discharge assessments were not done as recommended in the previous report especially regarding their being designed for the new environments. Surprisingly, there were no psychiatry discharge assessments done for any of the individuals.
- SGSSLC continued to make incremental progress in developing thorough comprehensive ENE support lists. Section T1e details this and focuses on a number of areas, including histories of behavioral and/or psychiatric problems, rewards and other aspects of PBSPs, health, employment, skills and activities, and implementation by provider.
- Since the last review, 43 post move monitorings for 20 individuals were completed. The post move monitoring report forms were completed correctly and thoroughly. Good information was included.

Guardianship and Consent

- Continued progress was seen. The human rights officer, assistant independent ombudsman, and human rights office administrative assistant worked very closely with individuals and their IDTs to ensure protection of rights at the facility. They were actively involved with every department at the facility and served as an invaluable resource to IDTs.

- The facility had recently revised the assessment process for determining the need for guardianship. IDTs were in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent.
- IDTs continue to need training to determine each individual's functional capacity to render informed decisions. Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- Good progress was evident across all four recordkeeping provision items. This was due, in large part, to the work of the new unified record coordinator (URC).
- A unified record existed for all individuals, including new admissions. The active records continued to improve. There were fewer blank gaps in the IPNs, observation notes, and physician's orders. There were no non-IPN documents in the IPNs.
- Even so, there continued to be many missing and/or incorrectly filed documents. Many documents were old, outdated, and/or expired. Updates and/or recent regularly scheduled reviews were not in the record. Some documents were not removed from the active record as required. Errors in legibility or correctness of handwritten entries and/or signatures and credentials, and/or missing signatures were observed in all of the active records (though this appeared improved somewhat from the previous review). Some data were missing from SAPs.
- SGSSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks. The individual notebooks tended to be stored away, locked in the home offices. Therefore, the notebooks did not appear to be readily available for use by DSP staff. SGSSLC maintained the same satisfactory system of managing the master records.
- The QA director re-built the facility's list of policies in response to the needs of provision item V2 and recommendations in the previous monitoring report. Included were the first attempts at data collection regarding training on policies.
- Continued progress was made in the reviews of the unified records. Five or more audits were conducted in each of the past six months. The new URC revised and improved the process beginning in September 2012. There were some graphic summaries of some data, but they needed to be improved.
- For V4, the facility showed progress by taking first steps to assess, and possibly address, the six activities of this provision item. For example, the URC revised the V4 tool and included items relevant to some of these activities.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of SGSSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement. The monitoring team looks forward to continuing to work with DADS, DOJ, and SGSSLC. Thank you for the opportunity to present this report.

II. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy: Use of Restraints 001.1 dated 4/10/12 o SGSSLC Policy: Management of Inappropriate Behavior dated 3/30/96 o SGSSLC Policy: PMAB Investigations dated 7/9/99 o SGSSLC Policy: Medical/Dental Restraint and Sedation Guidelines date 9/9/05 o SGSSLC Policy: Response to Behavioral Emergencies date 9/3/10 o SGSSLC Policy: Restraint Notification Process and Responsibilities of Restraint Monitors and Health Care Professionals date 3/31/11 o Restraint: Ordering, Assessing, and Evaluating Curriculum (RES0300) 08/12 o Restraint Monitor Curriculum o SGSSLC Self-Assessment o SGSSLC Provision Action Information Log o SGSSLC Section C Presentation Book o FY12 Restraint Trend Analysis Report o Sample of Incident Management Team Minutes o Restraint Reduction Performance Improvement Team Committee Minutes o List of all restraint by Individual 6/1/12 through 11/30/12 o List of all chemical restraints used for the past six months o List of all medical restraints used for the past six months o List of all restraints used for crisis intervention for the past six months o List of all mechanical restraints for the past six months o List of all restraint related injuries o SGSSLC "Do Not Restrain" list o List of individuals at high risk for osteoporosis and aspiration. o List of all individuals with a Crisis Intervention Plan (6) o List of individuals with desensitization plans or strategies to reduce the use of restraint o Desensitization plans for Individual #344, Individual #236, Individual #130, Individual #7, and Individual #18. o Medical Pretreatment sedation Restraint Documentation for: o Individual #288, Individual #201, Individual #146, Individual #59, Individual #178, Individual #294, Individual #116, Individual #18, and Individual #38. o Restraint Reduction Committee meeting minutes for past six months o Training transcripts for 24 SGSSLC employees o ISPs, PBSPs, Crisis Intervention Plans (when applicable), and ISPAs for: • Individual #9, Individual #346, Individual #24, Individual #11, Individual #148, Individual #362, and Individual #331.

- A sample of restraint documentation for crisis intervention including:

Individual	Date	Type
#9	9/29/12@3:45 pm	Physical
#9	9/29/12@ 3:46 pm	Physical
#9	9/29/12 @4:13 pm	Physical
#9	9/27/12@8:55 am	Physical
#9	9/27/12@3:25 pm	Physical
#9	9/27/12@3:31 pm	Physical
#9	9/27/12@3:33 pm	Physical
#9	9/27/12@3:34 pm	Physical
#9	9/27/12@3:38 pm	Physical
#9	9/26/12	Physical
#346	9/19/12@2:55 pm	Physical
#346	9/19/12@3:10 pm	Physical
#346	9/19/12@3:30 pm	Physical
#346	9/19/12@4:10 pm	Chemical
#346	9/9/12	Physical
#346	9/5/12	Physical
#346	9/3/12	Physical
#24	9/28/12@1:29 pm	Physical
#24	9/1/12@1:37 pm	Physical
#24	6/2/12@2:57 pm	Physical
#24	6/2/12@3:10 pm	Physical
#24	9/19/12@3:16 pm	Physical
#24	9/7/12@3:27 pm	Physical
#24	8/23/12@4:50 pm	Chemical
#148	9/25/12	Chemical
#100	9/27/12	Physical
#362	9/28/12@2:44 pm	Physical
#362	9/28/12@2:46 pm	Chemical
#11	9/24/12	Chemical
#11	9/30/12	Physical

<u>Interviews and Meetings Held</u>:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Dana Robertson, Provision Coordinator/Leader
- Cynthia Lackey, Restraint Reduction Coordinator

	o John Church, Psychologist o Jalown McCleery, Incident Management Coordinator o Michael Davila, QDDP Coordinator o Michael Fletcher, QDDP Educator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 12/2/12 and 12/3/12 o Unit 1 Morning Meeting o Administrative IDT Meeting o Annual IDT Meeting for Individual #48 and Individual #127 o Human Rights Committee Restraint Review Meeting 12/3/12 o QA/QI Committee Meeting o Restraint Reduction Committee Meeting 12/6/12
	Facility Self-Assessment: SGSSLC submitted its self-assessment. It was updated on 11/19/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility gathered data from audits completed using the section C audit tool developed by the state office to determine compliance with each provision. Additional activities similar to those engaged in by the monitoring team were also used to determine compliance for each provision item. For example for C2, the facility used results from the section C audit tool and reviewed Crisis Intervention Plans to ensure that a release criterion was included. For C5, a sample of restraint checklists and face-to-face assessment forms were reviewed to for documentation of monitoring and nursing assessments completed for each restraint incident. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings. Findings were similar to findings of the monitoring team for each provision item in section C. Both the monitoring team and the facility assigned a rating of substantial compliance to C2, C3, and C6. The facility self-assessment accurately identified barriers to compliance with C1, C4, C5, C7, and C8. The facility Provision Action Information Plan addressed areas of needed improvement. There had been considerable progress made in developing an adequate self-assessment process.

	Summary of Monitor's Assessment: DADS updated its restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The facility had reviewed the new policies and had begun implementing many of the requirements of the new policy, specifically, the new restraint checklists and monitoring guidelines. All requirements of the new policy had not yet been implemented, particularly in regards to protective mechanical restraints used for self-injurious behavior and medical restraints. Based on information provided by the facility, there were 485 restraints used for crisis intervention between 6/1/12 and 11/30/12 involving 34 individuals. This was a considerable decrease compared to the 623 restraints for crisis intervention reported the previous six months. A new data collection system had been implemented by the facility in the last quarter. There were 42 instances of dental/medical pretreatment sedation from 4/1/12 through 9/30/12. This list included both pretreatment sedation prior to medical appointments and mechanical restraints (mittens) used to promote healing. The facility reported that no individuals received pretreatment sedation prior to dental procedures. Action taken by the facility to address compliance with section C since the last monitoring visit included: • Informed Trauma Care training and consultation was provided to the psychologists. • Crisis Intervention Plans were developed for some individuals. • The restraint database was updated. Information regarding restraint trends was distributed to each home. • A restraint reduction coordinator was hired using grant money. • Posters describing restraint prevention strategies were place in all homes. • A systematic desensitization PIT was formed to address assessment and development of treatment interventions for individuals who receive pretreatment sedation. • A tool was developed to interview DSPs on their knowledge of restraint prevention strategies. One DSP was being interviewed daily by administrative staff. Overall, the facility made very good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. It was noted during the monitoring team observations, however, that many individuals were not involved in meaningful training for a majority of the day. The facility needs to continue to focus on providing meaningful training opportunities and active engagement during the day. Increased engagement in activities based on individual's preferences and needs should impact the number of behavioral incidents leading to restraint. The facility was in substantial compliance with three of the eight provision items (C2, C3, C6).

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The facility provided a list of all restraints used for crisis intervention between 6/1/12 and 11/30/12: • 485 restraints occurred. • 34 individuals were the subject of restraints. • Three individuals accounted for 253 restraints (52%). • 390 were personal hold restraints, • 21 were mechanical restraints (mittens), and • 74 were chemical restraints. This was a large decrease from the 623 crisis intervention restraints reported the previous two quarters (12/1/11-5/30/12). The facility had not begun to address protective mechanical or medical restraints to comply with the new statewide restraint policy. Restraint Plans had not yet been developed for individuals who were wearing protective mechanical restraints due to self-injurious behaviors or as medical protective devices. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. A number of individuals at the facility were wearing protective equipment (e.g., helmets). There was documentation of the use of mittens (as medical restraint), but not helmets. The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. The facility needs to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. There was no indication that plans to reduce the amount of time spent in restraint were addressed by the IDT. <u>Prone Restraint</u> Based on the state and facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training that prone restraint was prohibited. Based on a list provided by the facility of all restraints for the past six months, 0 (0%) showed use of prone restraint. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises. Sample #C.1 was a sample of restraints for six individuals,	Noncompliance

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		representing 6% of restraint records over the last six-month period and 18% of the individuals involved in restraints. The sample included 26 physical restraints and four chemical restraints. Three of the individuals in the sample had the greatest number of restraints. Three others represented some of the most recent restraints. The individuals in this sample were Individual #148, Individual #362, Individual #11, Individual #9, Individual #346, and Individual #24. • Individual #9 had 150 restraints. • Individual #346 had 80 restraints • Individual #24 had 23 restraints • These three individuals accounted for 52% of the 485 restraints for crisis intervention between 4/1/12 and 11/30/12. The new statewide restraint policy required that: • Restraints were not used unless necessary to prevent imminent physical harm in a behavioral crisis, to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior that has not yet been reduced by intensive supervision or treatment. • The least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior was used. • Restraints were not used as punishment, as part of a positive behavior support plan, for staff convenience, or in the absence of or as an alternative to treatment. • Prone and supine restraints were prohibited. <u>Other Restraint Requirements</u> The facility policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others, after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner, for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included documentation for 30 restraints. The following are the results of this review: • In 30 of the 30 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In 30 of 30 (100%) restraints, staff documented events leading to the behavior that resulted in restraints. Identifying events that occurred prior to the behavior leading to restraint should be beneficial in developing strategies to avoid situations that lead to behavioral outbursts. The facility had made significant	

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		improvements in documenting the precursors to crisis intervention restraints. Some examples where staff adequately described events leading to the behavior: o The restraint checklist for Individual #148 dated 9/25/12 noted that she became upset following an incident with her boyfriend. o The restraint checklist for Individual #100 dated 9/27/12 indicated that he became aggressive towards staff when staff over the number of tokens that he received for cleaning. • In 30 of 30 records (100%), staff documented that restraint was used only after other interventions had been attempted. State policies identified a list of approved restraints techniques. Based on the review of documentation for 30 restraints, 30 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> There were 42 instances of dental/medical pretreatment sedation from 4/1/12 through 9/30/12. This list included both pretreatment sedation prior to medical appointments and mechanical restraints (mittens) used to promote healing. The facility reported that no individuals received pretreatment sedation prior to dental procedures. A list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were 25 individuals with strategies to address dental/medical restraint and/or desensitization plans in place. A request for the last 10 desensitization plans developed by the facility was requested for review. Five plans were submitted. Only two of the five had been developed since the last monitoring visit. Desensitization strategies had not been developed for all individuals requiring restraint for routine medical procedures. The facility was not yet in compliance with provision C1. To do so: • The long-term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, and/or eliminate the restraint when possible. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm. • IDTs should focus on developing ISPs that support meaningful engagement throughout each individual's day. • The facility needs to examine systemic issues that result in behaviors leading to restraint including staffing patterns, staff training, environmental factors, and lack of individualized programming options. • The use of medical and dental pretreatment sedation for routine care should be	

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		addressed with individualized strategies, including but not limited to formal desensitization plans. It was not evident that many individuals were engaged in day programming based on support needs and preferences. The number of refusals to attend programming and treatment classes remained high at the facility. Without adequate programming in place it was difficult to determine if restraints were used in the absence of or as an alternative to treatment.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The new statewide restraint policy required that any individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others. It further required that if a Crisis Intervention Plan is in place, the plan must describe the behaviors that signal there is no longer an imminent risk of physical harm to self or others. Crisis Intervention Plans (CIPs) had been developed to replace Safety Plans for Crisis Intervention and comply with requirements of the new policy for six individuals. CIPs described behavioral indicators that would signal that the individual was no longer a danger to himself or others. Additional plans should be developed for individuals who require the frequent use of restraint for crisis intervention. Individual #346 had 80 restraints and Individual #24 had 23 restraints during the past six months. Neither had a CIP in place to direct staff in the use of restraint. The CIP developed in accordance with the new state policy was reviewed for Individual #9. The new plan described what interventions to attempt prior to restraint, what behaviors would lead to restraint, and what behaviors indicated that the individual was no longer a risk of harm to himself or others. Instructions were presented in a clear, easy to follow format. The Sample #C.1 restraint documentation for 25 physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. • 17 of 25 (68%) restraints reviewed indicated that the individual was released immediately when no longer a danger. Two restraint checklists in the sample did not indicate a release code (Individual #9 dated 9/29/12 and Individual #346 dated 9/3/12). The other five exceptions documented that the individuals were released because an approved hold could not be maintained. The longest physical restraint in the sample was 15 minutes. This was the maximum duration allowed by the new state policy before an attempt at release was required. Eight (32%) of the physical restraints in the sample lasted two	Substantial Compliance

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		minutes or less. The facility was in substantial compliance with C2. The facility should develop Crisis Intervention Plans for those individuals frequently restrained to guide staff in restraint prevention and implementation.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Review of the facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 24 of 24 (100%) had current training in RES0105 Restraint Prevention and Rules. • 12 of the 15 (80%) employees with current training who had been employed over one year completed the RES0105 refresher training within 12 months of the previous training. • 23 of 24 (96%) had completed PMAB training within the past 12 months. The facility investigator had not completed PMAB training. Although it is unlikely that she would be involved in restraints, she could be assigned to investigate allegations resulting from restraint. It is recommended that she complete PMAB training. • 11 of the 14 (79%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. Training for all staff was not completed within the required timeframes based upon the sample of training records used to assess compliance. The facility should ensure that training is completed annually as required by state policy. Even so, given the high percentages, C3 remained in substantial compliance.	Substantial Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is	Based on a review of 30 restraint records (Sample #C.1), documentation in 30 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention, protection from self-injurious behaviors, or to complete medical/dental procedures.	Noncompliance

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	prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	There were 42 instances of medical pretreatment sedation from 4/1/12 through 9/30/12. This list included both pretreatment sedation prior to medical appointments and mechanical restraints (mittens) used to promote healing. The facility reported that no individuals received pretreatment sedation prior to dental procedures. The facility "Do Not Restrain" list indicated that 16 individuals did require restraint for dental procedures. An accurate list will need to be developed for individuals who require sedation for routine dental care. Strategies should be developed to reduce or eliminate the need for restraint for those individuals. According to a list provided by the facility, strategies to minimize or eliminate the need for restraints had been developed for 25 individuals who required the use of pretreatment sedation. The facility had identified 45 individuals who had historically required the use of pretreatment sedation for medical/dental appointments. Some individuals on the list were recommended for further assessment. The facility had created a "Do Not Restrain" list. There were 25 individuals at the facility identified on this list for whom restraints would be contraindicated due to medical or physical conditions. The list specified what types of restraints should not be used. This was not a comprehensive list of individuals who might be at risk for injury due to restraint. Ten homes indicated that there were no individuals whose medical condition contraindicated the use of restraint. Some examples where individuals were not included on the restraint list, but risk factors would indicate otherwise were Individual #273, Individual #217, Individual #128, Individual #278, Individual #203, and Individual #90. All were at high risk for both osteoporosis and aspiration. There was no indication that any individual on the "Do Not Restrain" list had been restrained in the past six months. As noted in C1, the facility had not begun to document or review the use of protective mechanical restraints to comply with the new statewide restraint policy. A form to document the application of protective mechanical restraints had been developed in conjunction with the new policy. SGSSLC had not implemented the new form. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used. The facility was not yet in compliance with this provision item.	

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C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Review of facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This training was competency-based. Based on a review of 30 crisis intervention restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 30 out of 30 incidents of restraint (100%), there was assessment by a restraint monitor. The new restraint policy requires that the Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint used for crisis intervention. The assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 29 (97%) out of 30 instances. The exception was for Individual #9 on 9/27/12 at 8:55 am. The restraint monitor arrived at 9:13 am. Based on a review of 25 physical and five chemical restraints used for crisis intervention that occurred at the facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint (for a minimum of two hours with the use of chemical restraint) in 21 (70%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #9 dated 9/29/12 (late x3), 9/27/12, and 9/26/12 o Individual #346 dated 9/19/12 (noted refused, no time given) x2 o Individual #148 (chemical restraint not monitored for two hours o Individual #362 dated 9/28/12 Based on a review of nine medical pretreatment sedation restraints, there was documentation that a licensed health care professional conducted monitoring at least every 30 minutes for a minimum of two hours in nine (100%) of the instances of restraint. Only 11 (37%), however, met the new state policy requirement that a nursing assessment be completed within 15 minutes of the restraint initiation. The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy.	Noncompliance

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C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample of 30 Restraint Checklists for individuals in crisis restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 30 (100%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. • In 30 (100%), the date and time restraint was begun were indicated. • In 30 (100%), the location of the restraint was indicated. • In 30 (100%) restraints, staff documented events leading to the behavior that resulted in restraints. • In 30 (100%), the specific reasons for the use of the restraint were indicated. • In 30 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 30 (100%), the names of staff who applied/administered the restraint was recorded. • In 29 (97%) observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. The exception was the restraint for Individual #318. • In 25 (100%) of 25 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 29 (97%) of 30 restraints, the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. The exception was for Individual #346 dated 9/5/12. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 15 minutes in duration. In a sample of 30 records (Sample C.1), FFADs had been completed for 30 (100%). These forms were generally complete in checking all the required boxes on the form, supplemented with appropriate narrative. The attention to detail required to complete this documentation accurately had improved significantly since the last review. A sample of nine individuals subject to medical restraint was reviewed, and in nine (100%), there was evidence that the monitoring had been completed as required by the physician's order. A sample of five individuals who were the subject of a chemical restraint was reviewed. In five (100%), there was documentation that prior to the administration of the chemical restraint, the psychologist was present and assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint	Substantial Compliance

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		had been met. The psychiatrist was notified and ordered the chemical restraint in each case. The facility maintained substantial compliance in regards to adequately documenting restraint incidents.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to SGSSLC documentation, during the six-month period prior to the onsite review, a total of 18 individuals were placed in restraint more than three times in a rolling 30-day period. This represented a decrease from the 20 individuals placed in restraint more than three times in a rolling 30-day period reported during the last review, and the 25 reported in the December 2011 review. Five of these individuals (i.e., Individual #362, Individual #331, Individual #100, Individual #24, and Individual #9) were reviewed (28%) to determine if the requirements of provision C7 of the Settlement Agreement were met. PBSPs, crisis intervention plans, and ISP addendums (ISPAs) following more than three restraints in 30 days were requested for all five individuals. A crisis intervention plan was not available for Individual #24, Individual #100, or Individual #362. Minutes from ISPA meetings following more than three restraints in a rolling 30-day period were not available for Individual #100 or Individual #362. A PBSP was not available for Individual #100. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in noncompliance because not every individual who met criterion had documentation of a ISPA meeting following more than three restraints in a rolling 30-day period occurred, and the available ISPAs did not consistently reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors and an action plan for modifying them to prevent the future probability of restraint. Two (i.e., Individual #9 and Individual #24) of the three (67%) ISPAs reviewed reflected a discussion of how an individual's adaptive skills, and biological and/or psychological factors may have contributed to the behaviors that provoked restraint. Both ISPAs listed psychiatric diagnoses as contributing to the behaviors provoking restraint indicated that these factors were addressed in ongoing psychiatric review meetings. This represented	Noncompliance

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		an improvement from the last review when none of the ISPAs reviewed reflected a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and a plan to address them. In order to achieve substantial compliance with this provision item, the minutes from each individual's ISPA meeting following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(b) review possibly contributing environmental conditions;	Two of the three ISPAs reviewed (67%) reflected a discussion of possibly contributing environmental conditions. Individual #24's ISPA hypothesized that boredom may contribute to her dangerous behavior that provoked restraint, and discussed a plan to ensure she was provided with meaningful activities throughout the day. Individual #9's ISPA reflected a discussion that concluded that no consistent environmental conditions were contributing to her self-injurious behavior (SIB). This represented another improvement from the last review when none of the ISPAs reviewed reflected a discussion of possibly contributing environmental conditions. In order to achieve compliance with this provision item, each ISPA meeting minutes following more than three restraints in a rolling 30-day period should reflect a discussion of possible contributing environmental factors (e.g., noisy environments), and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Two of three ISPAs reviewed (67%) reflected a discussion of potential environmental antecedents to the behaviors that provoked restraint, and a discussion of an action plan to address these antecedents. Individual #24's ISPA suggested that an antecedent to her SIB was staff requests. The ISPA reflected a discussion that staff should be reminded to use prompts and reinforce her replacement behavior (described in her PBSP) when staff placed demands on her. Individual #9's ISPA identified specific objects (e.g., bags and key chains) that she attempted to organize, and when she could not, engaged in SIB. The treatment team suggested limiting access to those items. This represented another improvement over the last review when none of the ISPAs reviewed reflected a discussion of potential environmental antecedents. In order to achieve compliance with this provision item, ISPA minutes need to reflect a discussion of the effects of these types of variables on the individual's behavior, and (if they are hypothesized to affect restraints) a discussion of an action plan to eliminate these antecedents or reduce their effects on the dangerous behavior that provokes restraint.	Noncompliance

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	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. One (Individual #9's) of the three ISPAs reviewed (33%) included a discussion indicating that the team hypothesized sensory stimulation was one variable that maintained Individual #9's SIB which provoked restraint. Individual #9's ISPA minutes also reflect a discussion of providing sensory stimulatory equipment non-contingently to address this hypothesis. This represented an improvement from the last review when none of the ISPAs reviewed discussed potential maintaining variables and actions to address those contingencies. In order to achieve compliance with this provision item, each Individual's ISPA should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint. The ISPA minutes should also reflect an action (e.g., increase staff attention for appropriate behaviors, etc.) to address this potential source of motivation for the target behavior that provokes restraint.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Four of the five individuals reviewed (80%) had PBSPs to address the behaviors provoking restraint. The following was found: • Four of the four PBSPs reviewed (100%) were based on the individual's strengths, • Four (100%) of the PBSPs reviewed specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors), • Four of the four PBSPs reviewed (100%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • All four of the PBSPs (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Two of the four PBSPs reviewed (50%) to weaken or reduce the behaviors that provoked restraint, however, were determined to be incomplete (i.e., Individual #24 and Individual #331) because they did not contain clear, precise interventions based on a functional assessment. Two of the five individuals reviewed (40%) had crisis intervention plans. The following represents the results: • For both of the crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • For both of the crisis intervention plans reviewed (100%), the maximum duration of restraint authorized was specified, • In both of the crisis intervention plans reviewed (100%), the designated	Noncompliance

#	Provision	Assessment of Status	Compliance
		approved restraint situation was specified, and • In both of crisis intervention plans reviewed (100%), the criteria for terminating the use of the restraint were specified.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	One (i.e., Individual #9) ISPA (33%) indicated treatment integrity data were collected, and that her plan was implemented as written. This was an improvement from the last review when integrity data were not available for any of the individuals reviewed. In order to achieve substantial compliance with this provision item, all individuals who were placed in restraint more than three times in a rolling 30-day period, should have integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	All three of the ISPAs reviewed (i.e., Individual #331, Individual #9, Individual #24) indicated that their PBSPs were reviewed and determined to be appropriate. There was no evidence, however, that Individual #100's and Individual #362's PBSPs were reviewed and/or modified (when necessary) to decrease the future probability of them requiring restraint. In order to achieve substantial compliance with this provision item, all individuals who were placed in restraint more than three times in a rolling 30-day period, should have evidence of a review, and revision when necessary, of the adequacy of the PBSP.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	According to policy, the review of each incident of restraint began with a FFAD completed by a restraint monitor immediately following the restraint. The FFAD included an area for recommendations regarding the restraint. Restraint monitors were routinely making recommendations, but there was no indication that follow-up to recommendations was being tracked. Restraints were reviewed at the daily Unit Meeting and the daily Incident Management Team meeting, within three business days. Additionally, the restraint was reviewed by the section C provision leader. During the onsite monitoring visit, Incident Management Team meetings were observed and, during this timeframe, discussion of restraint was evident on the day after the episode. A summary of the restraint episode was presented at the meeting and preliminary recommendations were made and referred to the IDT for follow-up.	Noncompliance

#	Provision	Assessment of Status	Compliance

		For the 30 restraints in sample C1,
		• 30 of 30 (100%) were reviewed immediately by a restraint monitor.
		• 28 of 30 (93%) were signed by the unit director indicating review within three business days. Exceptions included:
		  o Individual #11 dated 9/24/12 (reviewed 10/1/12)
		  o Individual #346 dated 9/5/12 (reviewed 9/11/12)
		• 28 of 30 (93%) were signed by the IMT designee indicating review within three business days.
		  o Individual #11 dated 9/24/12 (reviewed 10/1/12)
		  o Individual #346 dated 9/5/12 (reviewed 9/11/12)
		• Two of two (100%) chemical restraints were reviewed by the psychologist within three days. The new statewide policy now required a review by the psychiatrist and pharmacist, as well. None had been reviewed by the psychiatrist or pharmacist.
		
		The facility should ensure that the use of mechanical protective restraints are documented, monitored, and reviewed in accordance with the new state policy. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used.
		
		The Restraint Review Committee (RRC) met regularly and reviewed restraint trends. The monitoring team observed an RRC meeting while onsite. Committee members analyzed data presented and discussed possible action to reduce any trends identified.
		
		Although there had been considerable progress made in terms of ensuring that restraint reviews were documented, the facility was not yet in substantial compliance with this provision item. ISPs should document discussion regarding the use of protective mechanical restraints for self-injurious behavior or medical purposes to include a schedule for monitoring, release, and reduction or elimination when considered clinically justifiable.	

Recommendations:

1. Address trends that contributed to behavior leading to restraint at the facility. Focus on providing meaningful training opportunities and active engagement during the day. (C1).

2. The long-term use of protective mechanical restraints and medical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, and/or eliminate the restraint when necessary. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm (C1, C2, C4, C8).

3. The facility should develop Crisis Intervention Plans for those individuals frequently restrained to guide staff in restraint prevention and implementation (C2).

4. Ensure all staff responsible for applying restraint techniques s have successfully completed competency-based training on approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint (C3).

5. Develop treatments or strategies to reduce restraint use for all individuals who required the use of medical or dental restraints (C4).

6. Monitoring by a nurse should be conducted and documented as required by state policy (C5).

7. Each individual's ISPA meeting minutes following more than three restraints in 30 days should reflect a discussion of each of the issues presented in C7a-d, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, there should be evidence that each individual's PBSP has been implemented with integrity, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent) (C7).

8. Document discussion regarding the use of protective mechanical restraints for self-injurious behavior or medical purposes to include a schedule for monitoring, release, and reduction or elimination when considered clinically justifiable (C8).

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Section D Presentation Book o SGSSLC Section D Self-Assessment o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o Preventing Abuse, Neglect, Exploitation training curriculum dated April 2012 o SGSSLC Policy: Management of Conduct Between Staff and Persons Served dated 3/30/95 o SGSSLC Policy: Spurious Allegations of Abuse/Neglect/Exploitation dated 3/30/11 o Information used to educate individuals/LARs on identifying and reporting unusual incidents o Incident Management Committee meeting minutes for each Monday of the past six months o Human Rights Committee meeting minutes for the past six months o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Training and background checks for the last three employees hired o Training transcripts for DFPS investigators assigned to complete investigations at SGSSLC o Abuse/Neglect/Exploitation Trend Reports FY12 o Injury Trend Reports FY12 o List of incidents for which the reporter was known to be the individual or their LAR o Spreadsheet of all current employees results of fingerprinting, EMR, CANRS, NAR, and CBC if a fingerprint was not obtainable o Results of criminal background checks for last three volunteers o A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #130, Individual #215, Individual #99, Individual #174, Individual #38, and Individual #379. o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, PBSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of all injuries for the past six months o List of all ANE allegations since 4/1/12 including case disposition o List of all investigations completed by the facility since 4/1/12 o List of employees reassigned due to ANE allegations o List of staff who failed to report ANE, or failed to report in a timely manner o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect.

- Documentation from the following completed investigations, including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42522683	Neglect (3)	Confirmed (1) Inconclusive (2)	10/22/12 10:33 pm	10/23/12 1:11 pm	11/1/12
#42530937	Emotional/Verbal Abuse (4) Physical Abuse (4)	Unconfirmed (4) Unconfirmed (4)	10/30/12 11:16 am	10/31/12 9:30 am	11/9/12
#42467986	Physical Abuse	Unconfirmed	9/17/12 11:03 am	9/17/12 2:59 pm	9/27/12
#42469162	Physical Abuse	Unconfirmed	9/17/12 9:34 pm	9/18/12 10:07 am	9/25/12
#42466936	Neglect	Inconclusive	9/16/12 1:00 am	9/16/12 1:46 pm	9/28/12
#42466453	Emotional/Verbal Abuse	Unconfirmed	9/15/12 10:38 am	9/16/12 1:35 pm	9/28/12
#42466213	Neglect (6)	Confirmed (4) Unconfirmed (2)	9/15/12 12:22 am	9/15/12 9:59 am	9/25/12
#42449597	Physical Abuse	Confirmed	9/4/12 12:50 pm	9/5/12 11:30 am	9/14/12
#42443238	Emotional Verbal Abuse Physical Abuse	Confirmed Confirmed	8/21/12 2:30 pm	8/30/12 3:08 pm	9/13/12
#42441653	Neglect	Confirmed	8/28/12 12:50 pm	8/29/12 10:17 am	9/4/12
#42443771	Emotional Verbal Abuse	Inconclusive	8/29/12 10:14 pm	8/30/12 5:26pm	9/13/12
#42441065	Neglect (2)	Unconfirmed (2)	8/27/12 11:19 pm	8/28/12 4:55 pm	9/13/12
#42434009	Neglect Physical Abuse	Inconclusive Inconclusive	8/23/12 7:47 am	8/23/12 2:25 pm	9/2/12
#42417374	Physical Abuse (3)	Unconfirmed (3)	8/11/12 3:19 am	8/11/12 7:36 pm	8/20/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#42498521	Sexual Incident Neglect	Administrative/Rights Issue	10/8/12	10/11/12	7/12/12
#42448788	Neglect	Clinical Issue	9/4/12	9/4/12	9/13/12
#42444500	Emotional/Verbal Abuse	Administrative Issue	8/30/12	9/6/12	9/11/12
#42443627	Emotional/Verbal Abuse	Administrative Issue	8/29/12	8/30/12	9/6/12
#42396982	Neglect	Administrative Issue	8/6/12	8/6/12	8/9/12
#42409878	Neglect	Clinical Issue	8/8/12	8/22/12	9/4/12
Sample D.3	**Type of Incident**	**Date/Time of Incident Reported**	**Director Notification**		
#5259	Serious Injury	9/14/12 3:00 am	9/14/12 3:35 am		
#5256	Serious Injury	9/11/12 6:30 pm	9/12/12 1:45 pm		
#5250	Sexual Incident	9/6/12 4:00 pm	9/6/12 4:16 pm		
#5244	Serious Injury	9/2/12 12:28 am	9/2/12 11:30 am		

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs;
- Dana Robertson, Provision Coordinator
- Mary Barrera, Acting Incident Management Coordinator
- Jalown McCleery, Incident Management Coordinator
- Michael Davila, QDDP Coordinator
- Michael Fletcher, QDDP Educator

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 12/2/12 and 12/3/12
- Unit 1 Morning Meeting
- Administrative IDT Meeting
- Annual IDT Meeting for Individual #48 and Individual #127

	o Human Rights Committee Restraint Review Meeting 12/3/12 o QA/QI Committee Meeting o Restraint Reduction Committee Meeting 12/6/12
	Facility Self-Assessment: SGSSLC submitted its self-assessment. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility implemented an audit process using similar activities implemented by the monitoring team to assess compliance. For example, for D2b, the facility completed a sample of 12 section D monitoring tools and reviewed the AP reassignment logs to determine if all APs were removed from contact with individuals immediately and remained in a no contact position until determined not to be a threat to individuals. The facility was using the statewide section D audit tool, supplemented by additional activities for each provision item. The facility's review of its own performance found compliance with 20 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 19 of the 22 provision items. Both the facility and the monitoring team did not find compliance with the requirements of D2i and D4. The facility self-assessment indicated that compliance had not been met with the requirements for audits to ensure all injuries were investigated (D2i) and requirements for trend analysis of incidents (D4). Additionally, the monitoring team was unable to confirm compliance with the requirement that the facility implemented action promptly and thoroughly, and tracked actions and the corresponding outcomes following unusual incidents (D3i). The facility is to be commended for its continued focus on developing an adequate self-assessment process to monitor compliance with section D requirements.
	Summary of Monitor's Assessment: According to a list provided by SGSSLC, DFPS conducted investigations of 491 allegations at the facility since April 2012, involving 162 allegations of physical abuse, 46 allegations of sexual abuse, 163 allegations of verbal/emotional abuse, three allegations of exploitation, and 117 allegations of neglect. Of the 491 allegations, there were 13 confirmed cases of abuse and 22 confirmed cases of neglect. An additional 60 other serious incidents were investigated by the facility.

	There were a total of 2133 injuries reported between 4/1/12 and 9/30/12. These 2133 injuries included 30 serious injuries resulting in fractures or sutures. The facility was not adequately addressing injuries and trends of injuries. Many of the serious injuries were preceded by similar incidents, not adequately addressed. The facility needs to aggressively address trends in injuries and implement protections to reduce these incidents and injuries. The facility had made substantial progress in addressing compliance with section D, though had made little progress in addressing factors contributing to the large number of incidents and injuries at the facility. The facility was just beginning to make appropriate recommendations with a focus on systemic issues that were identified following investigations, incidents, and injuries. According to data gathered by the facility, some systemic issues that contributed to a large number of incidents and injuries at SGSSLC included: • Behavioral issues, • Lack of adequate supervision, • Failure to carry out support plans as written, • Failure to revise supports when supports are not effective for preventing incidents, and • Lack of adequate individualized planning and supports. To move forward, the incident management department should take an integral role at the facility in looking at both systemic issues that contribute to incidents and individualized supports and services that place individuals at risk. The department will need to be involved in the emerging risk identification process to ensure that when individuals are at risk, adequate supports are provided.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats • Theft by staff • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a summary of abuse, neglect, and exploitation investigations provided to the monitoring team, investigations of 491 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 4/1/12 and 9/30/12. From these 491 allegations, there were: • 162 allegations of physical abuse, • 46 allegations of sexual abuse, • 163 allegations of emotional/verbal abuse, • 117 allegations of neglect, and • 3 allegations of exploitation. • 35 allegations were confirmed, including 13 abuse allegations and 22 neglect allegations. • 320 allegations were unconfirmed, and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• 24 allegations were found inconclusive. There was not enough evidence to determine an outcome. • 19 were unfounded. • 89 did not meet the definition of abuse or neglect and were referred back to the facility for further investigation. • Additional outcomes were pending for 4. The facility FY12 trend report showed that there were 60 other investigations of serious incidents not involving abuse, neglect, or exploitation between 4/1/12 and 9/30/12. This included: • 21 serious injuries/determined cause • 4 serious injuries/peer-to-peer aggression, • 2 serious injuries/undetermined cause, • 1 deaths, • 16 sexual incidents, • 3 unauthorized departures, • 2 suicide threats, • 7 choking incidents, • 2 encounters with law enforcement, • 1 pregnancy, and • 1 other (not specified). From all investigations since 6/1/12 reported by the facility, 24 investigations were selected for review. The 22 comprised three samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample (14 cases). • Sample #D.2 included a facility investigation that had been referred to the facility by DFPS for further investigation (6 cases). • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (4 cases). Based on a review of the 14 investigative reports included in Sample #D.1: • 13 of 14 reports in the sample (93%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. DFPS case #42449597 was a confirmed case of physical abuse. The incident occurred on 8/31/12, but was not reported until 9/4/12. • 14 of 14 (100%) indicated the facility director or designee was notified within one hour by DFPS. • 14 of 14 (100%) indicated OIG or local law enforcement was notified within the	

#	Provision	Assessment of Status	Compliance
		timeframes required by the facility policy when appropriate. • 13 of 14 (93%) documented that the state office was notified as required. The exception was DFPS case #42449597 In reviewing Sample D.3 (serious incidents), documentation indicated: • Three of four (75%) were reported immediately (within one hour) to the facility director/designee when the incident was discovered. In UIR #5244, the individual sustained a laceration to the head from a fall at 12:28 am. The facility director was notified on 9/2/12 at 11:30 am. • Documentation of state office notification, as required by state policy, was found in four of four (100%) UIRs. • Documentation of DADS Regulatory notification was required for two incidents. Notification was made as required in both cases (100%). The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR that contained information about notifications was included in: • 14 out of 14 (100%) investigation files in Sample #D.1. • 10 of 10 (100%) investigation files in Sample #D.2 and Sample #D.3. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was a random sample of 24 employees at the facility. All employees (100%) in the sample had signed this form. The facility was in substantial compliance with the requirements of D2a.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at	The facility had a policy in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 14 investigation reports included in Sample D.1, in 14 out of 14 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. The monitoring team was provided with a log of employees who had been reassigned since 4/1/12. The log included the applicable investigation case number, outcome of the case, disciplinary action taken (including retraining), and the date the employee was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	returned to work. All allegations were discussed in the daily IMRT meeting and protections were reviewed. In 14 out of 14 cases (100%), there was no evidence that the employee was returned to his or her previous position prior to the completion of the investigation or when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 14 investigation files in Sample D.1, 12 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of placing the AP in a position of no client contact, an emotional assessment, a head-to-toe assessment by a nurse, and changes in level of supervision when applicable. The facility was in substantial compliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included seven employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 13 (86%) of 15 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 12 (80%) of the 15 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with five direct support staff in various homes and day programs: • Five (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. The facility was in substantial compliance with this provision.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. A sample of this form was reviewed for a random sample of 24 employees at the facility. All employees (100%) in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported two cases involving a total of six employees where staff failed to report abuse or neglect as required. All staff were required to complete retraining on reporting procedures. The monitoring team assigned a substantial compliance rating to this provision.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of six ISPs developed after 6/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #130, Individual #215, Individual #99, Individual #174, Individual #38, and Individual #379. • Six (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. Abuse and Neglect Resource Guides were also distributed to individuals attending the self-advocacy meetings. The Rights and Protection Officer met with the self-advocacy group in May 2012 and September 2012 to remind individuals how to report allegations of abuse or neglect, as well as, how to report other complaints that did not involve A/N/E.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		In informal interviews with individuals during the review week, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. The facility was in substantial compliance with this item.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The facility safety officer reported that monthly rounds were made of each residential and day site to ensure ANE information and rights posters were in place in all buildings. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with his name, picture, and contact information. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 14 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in all (100%), as appropriate. OIG investigated seven cases in the sample and substantiated criminal activity in one case (DFPS #42443238). The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • SGSSLC Policy addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of SGSSLC.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	• Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this occurred. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. No names were submitted. Based on a review of investigation records (Sample #D.1), there were no other concerns noted related to potential retaliation for reporting. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility: • Reviewed all reported injuries at the morning unit meetings and again at the daily IMRT meetings. • Quarterly data reports were used to identify trends in injuries. Sample #D3 included investigations completed on a sample of three serious injuries. All four investigations were completed by the facility. It was noted that the September 2012 quarterly injury trend report indicated that there were 30 serious injuries documented between 4/1/12 and 9/30/12. The unusual incident trend report for the same time period showed 21 serious injuries were investigated by the facility. The investigation of all unknown injuries had been moved from the Risk Management Department to the Incident Management Department. The Risk Management Department audited a sample of home logbooks, nurse's notes, and physician notes to ensure all injuries were reported using a standardized client injury report form. The facility planned to continue these audits monthly. Problem areas had not been identified, thus far. The state reported that a new policy had been drafted to offer facilities further direction in developing an adequate injury audit system. The monitoring team will comment further on the new policy during the next round of reviews. Based on observations and the sample of documentation reviewed, the facility's audit system was in the beginning stages and not yet adequate for ensuring that injuries or trends of injuries were reported for investigation. The facility was not yet in substantial compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting investigations and working with people with developmental disabilities. Twelve DFPS investigators were assigned to complete investigations at SGSSLC. The training records for DFPS investigators were reviewed with the following results: • Twelve investigators (100%) had completed the requirements for investigations training. • Twelve DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SGSSLC had 12 employees designated to complete investigations. This included the IMC, Facility Investigator, Rights and Protections Officer, and Campus Administrators. The training records for those designated to complete investigations were requested, but not provided by the facility. Training transcripts were reviewed at the last monitoring visit and all investigators had completed training requirements. Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility remained in substantial compliance with this item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that staff did not cooperate with any outside agency conducting investigations. The incident management coordinator continued to meet quarterly with representatives from OIG and DFPS to discuss any systemic issues with investigations. Office space was available at the facility for outside investigators to conduct interviews and complete paperwork. The facility identified five staff across two investigations who failed to cooperate with investigators in the past six months. Disciplinary action was taken in all five cases.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 14 investigations completed by DFPS (Sample #D.1), OIG investigated seven of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The SGSSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.3): • There was no indication that evidence was not safeguarded during any of the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		investigations. Video surveillance was in place throughout SGSSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations noted the date and time of initial contact with the alleged victim. o Contact with the alleged victim occurred within 24 hours in 12 of 14 (86%) investigations. Contact was the made the following day in the remaining two cases (#42443238 and #42441065). It did not appear that a delay in contact with the alleged victim impacted the outcome of any of the cases in the sample. o Fourteen (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. This included gathering documentary evidence and making initial contact with the facility. • Twelve of 14 (86%) were completed within 10 calendar days of the incident. Extensions were filed in both cases (100%) that were not completed within 10 calendar days. The lengthiest investigation in the sample was DFPS #42441065, which was completed in 17 days. An extension had been filed on the 10th day because additional interviews were needed. • The facility incident management team continued to work closely with DFPS to facilitate timely completion of investigations. • All 14 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below in section D3f. • In nine of the 20 (45%) DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Six of those cases resulted in a referral back to the facility for further investigation. Concerns were appropriate based on evidence gathered during the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3: • The investigation began within 24 hours in seven of four cases (100%). • Four of four (100%) indicated that the investigator completed a report within 10 days of notification of the incident.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• All included recommendations for corrective action. Investigations commenced and were concluded in a timely manner.	

	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	DADS Incident Management Policy required a UIR to be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the facility investigations are discussed separately.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		• For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following:
		o In 14 (100%), each serious incident or allegations of wrongdoing;
		o In 14 (100%), the name(s) of all witnesses;
		o In 14 (100%), the name(s) of all alleged victims and perpetrators (when known);
		o In 14 (100%), the names of all persons interviewed during the investigation;
		o In 14 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In 14 (100%), all documents reviewed during the investigation;
		o Facility UIRs included a review of all previous investigations involving the alleged victim.
		o In 14 (100%), the investigator's findings; and
		o In 14 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of four facility investigations included in sample #D.3
		• The report utilized a standardized format that set forth explicitly and separately, the following:
		o In four (100%), each serious incident or allegations of wrongdoing;
		o In four (100%), the name(s) of all witnesses;
		o In four (100%), the name(s) of all alleged victims and perpetrators when known;
		o In four (100%), the names of all persons interviewed during the
			Substantial Compliance

#	Provision	Assessment of Status	Compliance
		investigation; o In four (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. o In four (100%), all documents reviewed during the investigation; o In four (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim known to the investigating agency. o In four (100%), the investigator's findings; and o In four (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 14 DFPS investigations included in Sample #D.1: • In 14 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Sample #D.1, • 14 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 14 of 14 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. Two daily review meetings (IMRT) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility Investigations • In four of four (100%) UIRs from sample #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report within five working days of completion. • Four of four UIRs included recommendation for follow-up. o Adequate documentation of follow-up to serious incidents, however, was not found in three of the investigations in the sample. See D3i for additional comments.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for 24 out of 24 (100%) unusual incidents in the sample. A statement regarding review, recommendations, and follow-up was included on the review form.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in the sample. Five of 14 investigations in Sample D.1 included confirmed allegations of abuse or neglect. Documentation provided by the facility indicated that disciplinary action had been taken in five of five cases where allegations were confirmed. DFPS noted concerns or made recommendations in three (21%) of the cases in sample #D.1. The facility maintained documentation of follow-up action taken to address concerns and recommendations. • Documentation of follow-up to all DFPS concerns was found in three (100%) of the investigation files in the sample. • Additionally, the facility made recommendations for follow-up in seven of the 14 cases in sample #D1. Considerable progress had been made towards adequately following up on issues identified in investigations. o Careful consideration was given to implementing action to address specific issues identified during an investigation that would prevent similar incidents from occurring. o The facility was now documenting follow-up to all recommendations made in investigations. • The facility was now sufficiently following up on incidents to ensure that adequate protections were in place and remained in place. A number of serious injuries occurred following a string of similar incidents. For example, o In DFPS case #42522683 involving a confirmed allegation of neglect, the DFPS investigator noted a concern that observation checks were not being documented and the level of supervision logs were not being	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed by DSPs. The facility addressed the concerns by retraining staff, then also required that supervisory staff evaluate the effectiveness of retraining by performing weekly quality assurance checks and submitting results to the incident management department. o In DFPS case #42466936, involving an allegation of neglect, the DFPS investigator noted a concern that staff assigned to the alleged victim were required to document observations while ensuring that his hands were watched at all times. There was concern that the incident may have occurred when staff were documenting observations. The facility recommended retraining staff on completing a positive transfer of supervision. Supervisory staff were then required to provide documentation of staff's knowledge of the procedure by sampling home staff 30 days after retraining occurred. Sample #D.2 included six investigations that were referred back to the facility for further review. The facility documented follow-up in all six cases. Recommendations for programmatic actions were made in four of four cases reviewed for facility investigations in Sample #D.3. • Documentation of follow-up to recommendations was only documented in one of the investigative files in the sample (UIR #5256). • Investigative files for UIR #5259 and #5250 did not include documentation of follow-up to recommendations. • UIR #5244 was a serious injury investigation initiated when an individual fell resulting in a laceration to his head on 9/7/12. The UIR included recommendations for neurology and psychiatric consultations. A change of behavioral and mobility status had been noted prior to the fall. It was not evident that either assessment had been scheduled. An extension was requested on 9/28/12 for additional time to follow-up on recommendations. The facility needs to ensure that when a change in status is identified, new assessments are obtained as warranted to identify needed supports. • IMRT minutes for 9/28/12 did not reference discussion of follow-up for the four unusual incidents included in #D3 sample. All occurred in September 2012, so should have been included for discussion by the IMRT in minutes for that month. The timeliness of follow-up to investigation recommendations continued to be a problem. The IMC reported that a better tracking system was in place to monitor completion of recommendations. The IMRT minutes included a summary of when follow-up was completed. The IMC sent reminders to department heads when follow-up action was delinquent. The following is a summary of follow-up to investigations	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>reported from April 2012 through August 2012.

<table>
<tr><th>Month</th><th>Total # of recommendations</th><th>Completed</th><th>Open</th><th>Extensions Requested</th><th>Delinquent</th></tr>
<tr><td>April</td><td>126</td><td>77</td><td>49</td><td>32</td><td>11</td></tr>
<tr><td>May</td><td>105</td><td>71</td><td>34</td><td>25</td><td>14</td></tr>
<tr><td>June</td><td>57</td><td>39</td><td>18</td><td>20</td><td>2</td></tr>
<tr><td>July</td><td>49</td><td>19</td><td>30</td><td>8</td><td>5</td></tr>
<tr><td>August</td><td>46</td><td>13</td><td>33</td><td>27</td><td>0</td></tr>
</table>

The facility was not yet following up on all recommendations in a timely manner, documenting all follow-up action, and monitoring outcomes of the action for facility investigations. Considerable progress had been made, however, in regards to following up on DFPS investigations. See D4 for additional comments regarding follow-up on trends identified in regards to incidents at the facility. The facility was not in substantial compliance with this item.</td><td></td></tr>
<tr><td></td><td>(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.</td><td>Files requested during the monitoring visit were readily available for review at the time of request.

With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team.</td><td>Substantial Compliance</td></tr>
<tr><td>D4</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.</td><td>The facility had recently implemented the new statewide system to collect data on unusual incidents and investigations. Data were collected through the incident reporting system and trended by type of incident, staff alleged to have caused the incident, individuals directly involved, location of incident, date and time of incident, cause(s) of incident, and outcome of the investigation.

The facility was compiling data on a quarterly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and injuries. Trends were reviewed in QI Council meetings. The facility needs to address trends that have the potential for serious consequences.

The monitoring team rated D4 as being in substantial compliance in the last report since follow-up to trends and investigations was commented on in section D1. As noted in D1, the monitoring team is now commenting on policy rather than implementation in D1 and</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		rating D4 in regards to implementation. The facility made very little progress in addressing incident trends at the facility. As noted in the previous report, the monitoring team found a lack of focus on addressing factors that contribute to the high number of incidents and injuries at the facility. This is an important component of protecting individuals from harm. There had been little consideration given to addressing factors that contributed to incidents and injuries at the facility, such as lack of supervision, competently trained staff, ensuring preventative supports are in place, and availability of meaningful programming. The monitoring team expects to see the incident management department start to take a role in the facility's overall approach to addressing the frequency of occurrence of incidents and injuries at SGSSLC.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry.	Substantial Compliance

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		According to information provided to the monitoring team, for FY12, criminal background checks were submitted for 2232 applicants. There were 85 applicants who failed the background check in the hiring process and therefore were not hired. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self report criminal activity forms. • Signed acknowledgement forms were submitted for 24 of 24 employees (100%). The facility remained in substantial compliance with this provision item.	

Recommendations:

1. The incident management department should take an integral role at the facility in looking at both systemic issues that contribute to incidents and individualized supports and services that place individuals at risk (D1 and D4).

2. The facility needs to continue to implement an audit system that will identify problems that need to be addressed by the facility in reporting injuries for investigation (D2i).

3. Whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes (D3i).

4. Data collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate if data are accurate and how data can best be used to evaluate that progress (D4).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o SGSSLC facility-specific policies: • Quality Assurance Process, dated 4/14/11, update 4/19/12 • QA plan narrative 11/1/12 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Draft Section E self-assessment tool from state office, revised draft 11/7/12 o SGSSLC organizational chart, undated o SGSSLC policy lists, 5/25/12 o List of typical meetings that occurred at SGSSLC, (not provided) o SGSSLC Self-Assessment, 11/19/12 o SGSSLC Action Plans, 11/16/12 o SGSSLC Provision Action Information, most recent entries 11/16/12 o SGSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/4/12 o Quality assurance department QA benchmark meeting summaries, August 2012 to November 2012 o Quality assurance QA report section, once, September 2012 o Quality assurance department presentations to QI Council, once, 9/26/12 o SGSSLC DADS regulatory review reports, 6/1/12 through 10/09/12, no annual survey o List of all QA department staff and their assigned responsibilities, October 2012 o SGSSLC QA department meeting notes, monthly August 2012 through 11/9/12 (3 meetings) o SGSSLC data listing/inventory, hard copy and electronic version, 9/25/12 o SGSSLC QA plan narrative, 11/1/12 o SGSSLC QA plan matrix, 9/27/12 o Set of blank tools used by QA department staff (7) o Sets of completed tools used by QA department staff for: • 2 of the 7 tools • Other tools: QA nursing death review, QA nurse section H reviews o Trend analysis report, for all four components, for last two quarters, through 8/31/12 o Monthly QAD-SAC-Department meeting (i.e., benchmark): July 2012 to November 2012 (five) • Summary of meeting and benchmark activity data • Sets/pages of data and reports submitted by each department for each provision • Tables and graphs of the following, through November 2012: ▪ Each department's effort regarding QA-related benchmark activities ▪ Each department's self-rating scores on whatever tools were used by the department

	o Dental SAP, from discussion during Dental benchmark meeting with monitoring team o Blank, proposed form for new activity of departments holding their own QA meetings o SGSSLC QA Reports, monthly July 2012 to November 2012 (five) o Provision section rotation schedule showing what months each provision was to be included in the QA report and presented to QI Council o QI Council minutes, monthly 6/11/12 to 10/30/12, (5 meetings) o PIT, PET, work group reports, variety of documents o Administrative/clinical IDT meeting minutes, weekly, 8/16/12 to 12/6/12 (attended by the monitoring team) o SGSSLC Corrective Action Plan tracking • Active CAPs, 19 pages, 11/20/12 • Closed/complete CAPs, 48 pages, 11/20/12 • Graph of percentage of sections/provisions that updated their CAPs info, October 2012 o DADS SSLC family satisfaction survey online, April 2012 through September 2012, 25 respondents o Various emails regarding trying to determine individual satisfaction o Home meetings with individuals, notes from last two meetings, September 2012 o List of self-advocacy leadership 2012 o Self-advocacy monthly meeting minutes/notes, monthly June 2012 to November 2012, 5 meetings o Self-advocacy meeting handouts for meeting 11/1/12 o Aktion club minutes, July 2012-August 2012 (2) o Description of self-advocacy semester class, 10/17/12 o Facility newsletters, All About Us (1), Enlightener bimonthly (3) <u>Interviews and Meetings Held</u>: o Angela Kissko, Director of Quality Assurance o Misty Mendez, Settlement Agreement Coordinator o Leticia Williams, QA staff member o Andy Rodriguez, Settlement Agreement Coordinator, San Antonio SSLC o Unit Directors: Cedric Woodruff, Tricia Trout, Mandy Rodriguez o Roy Smith, Human Rights Officer, Zula White, Human Rights Office Assistant, Melissa Deere, Assistant Independent Ombudsman o Charles Njemanze, Facility Director <u>Observations Conducted</u>: o QI Council meeting, 12/4/12 o Self-advocacy meeting, 12/4/12 o Dental department benchmark meeting, 12/5/12 o Home meetings, 509A 12/5/12, 505A 12/6/12 o Administrative Integration IDT meeting, 12/6/12

	Facility Self-Assessment The QA director improved upon the previous self-assessment by including additional activities and outcomes. Overall, she looked at some, but not all of the items that are looked at by the monitoring team. A revised and still proposed statewide self-assessment for section E will be helpful in future self-assessments for this section. Further, the Monitors and DADS will likely have finalized the expected contents of each of the five items in this provision in the next few months. This should then result in a revision to the statewide self-monitoring tool which can then be used by the QA director for future self-assessments. The facility self-rated itself as being in compliance with E3 and in noncompliance with the other four provision items of section E. The monitoring team agreed with these self-ratings, however, as noted in the narrative report below, progress continued to be evident since the time of the last onsite review.
	Summary of Monitor's Assessment: There was good steady progress towards the creation and implementation of a comprehensive quality assurance program, and towards the achievement of substantial compliance. The three unit directors appeared to be engaging in a variety of QA-related activities, more so than at the time of any previous reviews. The QA plan narrative was much improved since the last review. Some further editing and some additional detail were needed. The QA data list/inventory (also called the monitoring matrix) continued to improve. The QA department should now ensure that all important types of data (i.e., key indicators) are included in the data list/inventory (as well as in the QA matrix). Departments were now to present their listing/inventory to QI Council twice per year. This process had just begun. During the presentation observed by the monitoring team, there were numerous problems with department's data listing/inventory, such as duplications, unclear descriptions, and disorganization. The monthly benchmark meetings continued. During these monthly one-hour meetings (there were more than a dozen), the QA director and SAC met with the section leader to review a variety of QA and Settlement Agreement related activities. More departments had created their own self-monitoring tools and/or modified the state tools. The QA director now required each section leader to provide an analysis of the data, not just a description of the data. The analysis was the section leader's explanation of the data. The QA director should now create a way of determining whether the section leader's analysis was of sufficient quality and adequacy. The QA report had improved in a number of ways, such as the inclusion of the last three months of data followed by a longer trended line graph for some of the data elements.

	The QI Council meeting observed by the monitoring team was organized, and participation was better than during the last onsite review (though not as much as usual according to a number of attendees who spoke with the monitoring team after the meeting). The facility director frequently participated. PITs and PETs continued to play an active role. The QA department should organize and better manage the PITs, PETs, and committees. The QA director continued to improve the CAPs system. It appeared, however, that CAPs were not yet identified for all areas of services and supports. Staff who were deemed responsible for CAPs were aware of their CAPs and of their responsibilities. CAPs were discussed and reviewed during the monthly benchmark meetings. Not all CAPs, however, were implemented fully and in a timely manner and many were not modified when needed.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The QA department at SGSSLC continued to make good steady progress towards the creation and implementation of a comprehensive quality assurance program, and towards the achievement of substantial compliance with provision E of the Settlement Agreement. Over the course of the past few monitoring reviews, and especially since the last review, additional components of the QA program were developed and implemented, in a coordinated manner, such that a more organized system of data reviews, and a more organized manner of addressing all provisions of the Settlement Agreement, was evident at the facility. Moreover, the QA department and its activities were well-known all over campus, by clinicians, department heads, and administrators. This was all good to see. <u>Policies</u> There were no changes to the state policy or to the facility policy regarding quality assurance. The QA plan narrative (see below) was added as an addendum to the facility policy. This made sense because the QA plan narrative described much of the facility QA program. The state policy called for a statewide QAQI Council, and for statewide discipline QAQI committees. Neither appeared to be in place at this time. Also, given that the statewide policy was in development for more than a year and was disseminated almost a year ago, edits may already be needed. State office should consider this. <u>QA Department</u> This ongoing continued progress noted above (and detailed below) was due to the efforts of the QA director, Angela Kissko and the Settlement Agreement Coordinator, Misty	Noncompliance

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		Mendez. Ms. Kissko was QA director for many years and Ms. Mendez was Settlement Agreement Coordinator for more than a year. They were responsive to comments and recommendations from the monitoring team over the past two years, and they worked in a collaborative manner with each other and with the many clinical and operational departments at the facility. The other QA department staff were experienced and in their jobs for a number of years. This included the two QA program auditors, two QA nurses, QA data analyst, and QA administrative assistant. The QA director recently updated each staff member's responsibilities. The updated descriptions were reasonable and well-written. The QA director started to hold monthly meetings for her staff. Agenda items for October 2012 and November 2012 were relevant to their work. The monitoring team recommends including a monthly topic related to the overall professional field of quality assurance. Also, the monitoring team would like to observe a QA staff meeting during the next onsite review, if possible. The three unit directors appeared to be engaging in a variety of QA-related activities, more so than at the time of any previous reviews. For example, the unit directors talked with the monitoring team about data, trending, and wanting more time to be able to analyze trended data. They talked about presenting and discussing injuries and peer to peer aggression at QI Council. The unit directors reported that they were attending and participating in more and more committees, such as the active treatment PIT. The QA director should consider ways of formally including the unit director's input into the QA program. One way might be to have a monthly QAD-SAC benchmark meeting with the unit directors. <u>Quality Assurance Plan Narrative</u> The QA director split the QA plan narrative and QA plan matrix into two different documents. This was fine to do because the QA plan narrative now described both the QA plan matrix and the data list inventory. Moreover, the QA plan narrative was now part of the facility QA policy (i.e., as an attachment). The QA plan narrative was much improved since the last review. It was only three pages long, but because it was succinctly written, it contained a lot of relevant information. Moreover, it included all of the sections recommended in the previous monitoring report. As discussed with the QA director, some further editing and some additional detail were needed. The QA director was already planning on doing this. Some areas are to further describe how the most important key indicators for each discipline are determined (in the QA inventory and/or QA matrix sections), a description of how inter rater reliability	

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		are collected for each department and where the results of these reliability checks are to be reported, such as during monthly benchmark meetings and/or the quarterly QA report, and where PIT and PET data are to be listed, such as in the data inventory for the discipline or in a separate category specifically for the PIT or PET. The 11/9/12 staff meeting minutes indicated that training was provided to the QA department on the QA plan narrative. In addition, the summary notes for the November 2012 benchmark meetings stated that each of the 20 section leaders was trained on the new QA plan narrative, too. <u>Quality Assurance Data List/Inventory</u> The QA data list/inventory (also called the monitoring matrix at SGSSLC) continued to improve since the last review. The number of departments/tabs grew from 19 to 22. When printed, the document was 37 pages (i.e., data lists for some departments were more than one page). Previous formatting and color coding problems were corrected. The QA director reported that the contents of the lists were getting better and better. The lists continued to contain two columns to indicate, for each type of data entered, whether it was included in the QA report and reviewed by QI Council, only reviewed during monthly benchmark meetings, or neither. Each list now also indicated when it was last updated and/or reviewed by the QI Council. Beginning about a two months ago, the data list/inventory for two or three departments were presented during QI Council so that QI Council attendees could learn more about all of the types of data that were collected by the department and so that QI Council attendees could request that some of these data be included in future QA reports and QI Council presentations. The intent was that senior management would become more aware of all of the data being collected at the facility, including some data of which they might not have been aware. The goal was to have each department's data list/inventory be presented twice a year. This was a very good new component to the QA program at SGSSLC. The monitoring team observed this presentation during the QI Council meeting during the onsite review. It was a presentation of the section K (psychology) data list/inventory. There was reasonable participation from the attendees, including the facility director requesting that three specific data elements be included in future QA reports and QI Council presentations. The presentation, however, showed that there were numerous problems with this listing of data, such as duplications, unclear descriptions, and disorganization. Thus, in addition to informing senior management of types of data, the review might also accomplish helping to make the lists as accurate and understandable as possible.	

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		Thus, evident to the monitoring team was the progress made by the QA director as well as the need for the lists/inventories to be more comprehensive, organized, understandable, and complete. To that end, the QA department should now ensure that all important types of data (i.e., key indicators) are included in the data list/inventory (as well as in the QA matrix). The QA director will need to have a plan to accomplish this. One way would be to request state office discipline coordinators to either review the data lists/inventories or to perhaps suggest a list of the most important indicators for each department. The QA director and SAC asked the monitoring team for suggestions regarding how to list data that are used by more than one department. This question itself demonstrated how far the QA program had developed. One way would be to merely cross-reference the listing if it was to occur in more than one list. <u>QA Plan Matrix</u> The QA matrix was used by the QA director, SAC, and discipline department leader. Because the quality and organization of the listings/inventories had improved, the QA matrix had become merely a subset of the listings/inventories. That is, any of the data elements that were marked as being included in the QA report and reviewed at QI Council were copied into the QA matrix. This was fine and acceptable. Further, all of the data marked in this way were also reviewed during the monthly benchmark meetings. Thus, the QA department (and the SAC) were reviewing these data each month and data submissions (narratives, graphs, tables) were submitted by the department leader. An improvement in the listings/inventories, including work on ensuring that key important indicators are included (as noted above) will likely result in additional and/or different choices of what is presented in the QA report and to QI Council. The monitoring team suggests that there be dividers that separate the items for each department to make it easier for the reader to understand the QA matrix contents. <u>QA Activities</u> •• Monthly QA Benchmark meetings: SGSSLC continued the monthly benchmark meetings that were described in the previous monitoring report. During these monthly one-hour meetings (there were more than a dozen), the QA director and SAC met with the section leader to review a variety of QA and Settlement Agreement related activities. The QA director and SAC collected data on each section leader's completion of 10 of these activities and then graphed and presented these results (e.g., departments ranged from 33% to 100% in November 2012). These	

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		benchmark meetings occurred regularly and consistently over the past six months. Monthly meetings were also supposed to be held for each PIT and PET. During the meeting, data were presented from the section leader regarding self-monitoring and regarding important key indicators. The QA director and SAC also kept a set of data tables and graphs that summarized the results of whatever self-monitoring the department conducted. This might be statewide self-monitoring tools, facility made self-monitoring tools, or a combination of both. Thus, there were two sets of data: one of the process/participation in activities, the other the work of the department (i.e., processes and outcomes of service and support provision). The monitoring team continued to be impressed by this organized and consistently-implemented system of regular review, updating, and reporting of data. Also, as recommended in the previous report, the statewide trend analysis report (which reported data on four specific areas) was now incorporated into the sections C and D benchmark meetings, QA report, and QI Council presentations. The QA director reported that she was considering using another SSLC's system of management of trend analysis report data. If any changes are made, the monitoring team will review them during the next onsite review. Another new component of the QA program was in the planning stages during the week of the onsite review. It was for each section leader (or a group of section leaders) to hold a QA meeting of their department(s). Some training was conducted (it was noted in the monthly benchmark meeting summaries) and a meeting guide and agenda were created by the QA director and SAC for use by the section leaders. The monitoring team observed the conduct of a monthly benchmark meeting. It was for the dental department. It was a good meeting during which the QA director, SAC, dental director (he was newly hired at the facility), and the dental assistant (who was very experienced at the facility) engaged in good discussion regarding monitoring, data, reporting, self-assessment, action plans, and corrective actions. The dental assistant commented that she thought the whole process was working great (i.e., monthly benchmark meetings). This was good to hear. •• QA Staff Activities: QA staff spent their time collecting data implementing their department's own QA tools (there were seven), completing department self-assessment tools to assess interobserver agreement (statewide and/or facility-made tools), and participating on various committees and in meetings.	

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		The seven were the program audit, individual support observation and interview, documentation audit, ANE interview, internal peer review mock survey, ISP monitoring checklist, and environmental checklist. The QA director should indicate how all of the data from these tools are collected, trended, reviewed, summarized, and presented. Consider that, of the seven: • a sample of completed tools were submitted to the monitoring team for only two: documentation audit, environmental checklist. (The tools were completed thoroughly and thoughtfully, and any resultant required actions were clearly documented, some via emails.) • data from only two (program audit, internal peer review mock survey) were included in the most recent section E QA report and QI Council presentation (September 2012). • only three were included in the data listing/inventory for the QA department (program audit, internal peer review mock survey, documentation audit). It may be that some of the data collected by the QA department for some of these seven tools were incorporated into other sections, such as D, F, and I. In addition, the QA department managed: • QA nurse section H tools (see section H of this report) • QA nurse death reviews (see sections L and M of this report) • FSPI • Satisfaction surveys (see below) •• Self-Monitoring Activities: SGSSLC made changes to the way it self-monitored performance for many of the provisions of the Settlement Agreement. This involved the creation of their own tools and in some cases a move to what they called 100% monitoring. This was for cases where all of the occurrences were monitored and assessed, such as for restraint usage. Last time, SGSSLC reported that it had its own tools for N, F, and H. At the time of this review, F and H tools continued to be used (and had been updated and improved), but the N tool was not being used. Further, there were new facility-made tools for sections C, K, M, and V. The section C and K tools were considered to be 100% monitoring tools. In addition to what was reported for the medical department (section L) in the benchmark meeting and QA report, external/internal audits were conducted and CAPs resulted. Even though the medical audit should be primarily handled by the medical department as part of its medical quality program (section L3), and even though at	

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		SGSSLC some of the data from the audits was managed via the section H lead, this information (audit results, CAPs, follow-up on CAPs) should eventually roll up to the QA department and be monitored/tracked by the QA department. The QA director and SAC were struggling with how to conduct inter rater agreement checks for some of these new tools and for those that did 100% monitoring. The monitoring team suggests a few possibilities. One is to sample from the 100% monitoring, that is, to only score some of what the section leader has scored and base the inter rater agreement calculation on only those. Another way is to think about inter rater reliability across the year rather than for every month. In this way, the QA department might concentrate on a certain percentage of observations over the year. Thus, inter rater agreement checks might not occur every month for every item. Third, the monitoring team suggests that QA director and SAC request assistance and suggestions from the state office coordinator for psychology. His knowledge and experience regarding inter rater agreement (i.e., reliability) procedures might be helpful to them. •• Satisfaction Measures: A variety of satisfaction measures are important indicators to include in a comprehensive QA program. Family and LAR satisfaction information continued to be collected regularly and shared with QI Council. This was done in the September 2012 QA report and QI Council meeting. Family satisfaction data were now managed by the QA director (as was all satisfaction data). There were 25 respondents over the previous six months, about the same rate (four per month) as last time. Some of the most useful information comes from the last two or three items, which are open ended questions. The responses to those were not included in what was given to the monitoring team. The QA director should review these and follow-up on any relevant comments, if any. Staff satisfaction was not being assessed at the facility at this time. A survey done a year ago was supposed to become an annual activity, but that was not yet occurring. A statewide DADS staff survey was conducted in February 2012 and the results should now be available to SGSSLC. Further, unit directors might be helpful in conducting a staff satisfaction assessment. The QA director made progress regarding occasional surveys of community businesses. Good, positive, feedback was received. She also collected data showing the number of individuals who went into the community at least once each month. The QA director also made progress in trying to determine the satisfaction of individuals. To that end, she spoke with the human rights officer and assistant independent ombudsman, and reviewed self-advocacy meeting minutes. She then reported on her findings in the QA report and QI Council meeting in September 2012. These were	

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		reasonable activities. She might next work with self-advocacy committee about how to conduct a satisfaction survey. Also, the weekly home meetings may provide another avenue for assessing individual satisfaction. The self-advocacy meetings and the self-advocacy group continued to mature and grow, under the facilitation of the human rights officer. His success with this was also due, in part, to his collaborative outcome-oriented working relationship with the assistant independent ombudsman, and with his rights office administrative assistant. Over the past two years, the monitoring team observed the self-advocacy meetings evolve from a litany of individual complaints about the facility to a problem solving approach whereby individuals participate in defining problems, generating ideas for solutions, and participating in implementing those solutions. The content of meetings now regularly included education about community life, too, including guest speakers from the community and/or from the facility. The meeting observed by the monitoring team was, as usual, well attended by approximately 50 individuals. One topic was the promotion of safety. Self-advocacy members had recently made a presentation to the facility's safety committee. This was great to see. The monitoring team recommends that the facility consider having a member of the self-advocacy committee as a regular member of the safety committee, if appropriate to do so. Also, the human rights officer might consider bringing the problem of peer to peer aggression to the self-advocacy committee to discuss because it relates to having a safe environment. Perhaps they can participate in developing and implementing solutions to this complex problem. Another topic for the self-advocacy group to take on might be ways to improve engagement and day activities. They might work along with the facility staff who are addressing this (i.e., the active treatment PIT, the section leaders for F and for S). The monitoring team also observed two weekly home meetings. These were wonderful opportunities for teaching choice making, problem solving, social skills, and so forth. The home managers lead these meetings. It appeared that they could use additional assistance and guidance (and perhaps training) on how to make the best use of these meetings, such as setting rules and expectations for the meetings, teaching respect for other individuals when they are talking, fostering proper participation, etc.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or	Continued progress was seen at SGSSLC regarding the analysis of data. <u>Monthly QAD-SAC meeting with discipline departments</u> These monthly meetings, called benchmark meetings at SGSSLC, occurred regularly over the past six months. Their conduct is described above in E1. The meetings were a good forum for the review of QA-related activities as well as review of process and outcome data for each section of the Settlement Agreement.	Noncompliance

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	prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	The QA director made further progress by requiring each section leader to provide an analysis of the data, not just a description of the data. The analysis was the section leader's explanation of the data. This was also good to see. The QA director should now create a way of determining whether the section leader's analysis was of sufficient quality and adequacy. There seemed to be some initial work on this because the most recent QA report, on page 32, noted that "…not all section leads are providing a monthly analysis or the quality of the analysis remains at an unacceptable level." Similarly, given that the QA director and SAC were not experts in content for every clinical discipline, there should also be a way to ensure that proper key indicators (for both process and outcomes) are identified and included in the analysis (similar to the comments made above about the QA data listing/inventory and QA matrix); and whether the graphic presentations are presenting the information to the reader in an understandable manner. <u>QA Report</u> There continued to be improvements in the QA report. It continued to be a monthly report, and continued to include data and analysis on performance on each of the Settlement Agreement provisions that were to be reviewed at QI Council that month. Each provision was now reviewed quarterly, thus, the provisions were grouped into three sets. The QA director and SAC created a thoughtful rotation schedule to ensure that each provision was reviewed quarterly, but also so that the monitoring team would not see the same grouping presented during every onsite review. This was appreciated. The QA report remained a regular and typical part of the QA program and QI Council. This was all good to see. The QA report had improved in a number of ways, some in response to recommendations from the previous monitoring report, and some due to the continual discussion between the QA director, SAC, and section leaders to make the QA report as useful and readable as possible. One improvement was the inclusion of the last three months of data followed by a longer trended line graph for some of the data elements. A second was inclusion of the statewide trend analysis report information into sections C and D. A third was more written analysis of data (though see comments immediately above regarding having some criteria for this). A fourth was reduced inclusion of CAP information, such that now, only new and/or modified CAPs were included. The monitoring team continues to have the suggestion that the QA director and SAC consider if there are any key indicators that should be in the QA report every month. These might be high profile important outcomes that may (should) be of interest to senior management every month, such as those related to injuries, allegations and confirmations, restraints, attendance at day programs and sessions, and so forth.	

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		QI Council: This meeting plays an important role in the QA program and is to be led by the facility director. The monitoring team attended a meeting during the onsite review and read the minutes of all QI Council meetings back to 6/11/12 (one each month). Section H presentations were moved to the administrative IDT meeting because of the length of time it took to review them. The report for section H was also lengthy and was no longer part of the regular QA report. Overall, the meeting observed was organized, and participation was better than during the last onsite review (though not as much as usual according to a number of attendees who spoke with the monitoring team after the meeting). The meeting had four parts. The first and largest was the presentation of the Settlement Agreement provisions scheduled for the meeting. The others were a review of the data listing/inventory for the selected provisions, presentation of benchmark activity completion data, and updates on any PITs and PETs. The facility director frequently participated. He asked for some data elements to become part of the regular quarterly presentations at QI Council, he told a presenter that he (the facility director) was always available for problem solving and that the presenter should come to him with a proposal for solving the problem raised during the meeting. Questions raised by other attendees were about data, graphing, action plans, and whether the presenter's interpretation of trends and slopes in the graphs were correct. The QA director pointed the attendees and the presenter to the topic at hand with statements, such as "Is there anything else you want to draw our attention to?" Only one PIT/PET, the committee on token systems, made a short presentation (see below). Administrative IDT meetings: Each week, the facility director led a meeting of senior management and section leader staff. This was in addition to the monthly QI Council. The meeting served a number of purposes. First, it provided a forum for case reviews of particularly challenging cases. This was in addition to the PNMT and BSC. Second, it provided an opportunity for the group to specifically focus on clinical service integration and management. Thus, the section H leader was now to present her monthly report to this group (rather than to QI Council). Also, meeting minutes showed occasional review and discussion of section G. Third, the meeting provided a frequent opportunity for the facility director and Settlement Agreement Coordinator to provide updates on Settlement Agreement-related topics. The monitoring team has just one recommendation regarding this meeting, that is, to not	

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		present individual clinical provider names and data in this public forum, such as the results of an individual physician's audit ratings. <u>Performance Improvement Teams</u> PITs and PETs continued to play an active role at SGSSLC. This was good to see. The system of managing and understanding PITs, PETs, committees, and work groups, however, was confusing. Further, the expectation for PIT/PET/committee participation in monthly benchmark meetings, the QA report, QI Council, and the QA data listing/inventory was in need of correction and improvement. It appeared, from meeting minutes, that most of the PITs had "re-focused" during the past few months. Further, the documents submitted to the monitoring team about PITs/PETs/committees were different from one another, some were not dated, etc. It seemed that there were: • Five PITs: HCCE, enteral, active treatment, desensitization, pain • Two PETs: Med variance, mealtimes • Two Committees: pneumonia, token systems (see Gary Flores) The QA department should organize and better manage the PITs, PETs, and committees. <u>Corrective Actions</u> The QA director continued to improve the CAPs system at SGSSLC. She now had two databases, one that listed active CAPs (19 pages, 40 CAPs, 11 Settlement Agreement provisions) and one that listed completed/closed CAPs (48 pages). Each CAP on the active list briefly described the CAP, the responsible person, start date and projected completion date, and brief comments on the status each month. It appeared that CAPs were not yet identified for all areas of services and supports. The QA director had begun to chart some data on CAPs and was planning to begin to include this information in the section E quarterly QA report and QI Council presentation. The data were a graph of the percentage of the 20 Settlement Agreement provisions that had updated the CAPs that month. This was an appropriate type of data, however, many sections, didn't have a CAP even though one or more may have been appropriate, but were not identified. In addition, she should consider also graphing these data each month: • Total number of active CAPs • Number of CAPs completed and closed out for the month • Number of CAPs that are active (i.e., not completed) past their due date	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	SGSSLC maintained substantial compliance with this provision item. Based upon the organized system of CAPs management at SGSSLC, the CAPs tracking form, observation during the onsite review, and discussions with various staff, the monitoring team found that staff who were deemed responsible for CAPs were aware of their CAPs and of their responsibilities.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	SGSSLC was not in compliance with this provision item. CAPs were discussed and reviewed during the monthly benchmark meetings. Not all CAPs were implemented fully and in a timely manner.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SGSSLC was not in compliance with this provision item. Although CAPs were discussed and reviewed during the monthly benchmark meetings, many were not modified when needed. Further, the QA director did not have a systematic method for determining which CAPs needed modification.	Noncompliance

Recommendations:

1. Include topics related to the overall professional field of quality assurance during QA staff meetings (E1).
2. Consider ways of formally including the unit director's input into the QA program (E1).
3. Further editing and some additional detail were needed in the QA plan narrative, including how the most important key indicators for each discipline are determined, a description of how inter rater reliability are collected for each department and where the results of these reliability checks are to be reported, and where PIT and PET data are to be listed.
4. The lists/inventories need be more comprehensive, organized, understandable, and complete. Ensure that all important types of data (i.e., key indicators) are included in the data list/inventory (as well as in the QA matrix) (E1).
5. In the QA matrix, add a divider to separate the items for each department (E1).
6. For the seven tools implemented by the QA staff, indicate how all of the data from these tools are collected, trended, reviewed, summarized, and presented (E1).
7. Determine how to obtain inter rater agreement for those self-monitoring activities that are called 100% monitoring (E1).
8. Examine the answers to the open ended questions in the family/LAR survey (E1).

9. Consider having a member of the self-advocacy committee as a regular member of the safety committee, if appropriate to do so. Consider bringing the problems of peer to peer aggression and active engagement to the self-advocacy committee (E1).

10. Consider providing more guidance/training to home managers regarding facilitation and leadership of the weekly home meetings (E2).

11. Create a way of determining whether the section leader's monthly and quarterly analyses of their data was of sufficient quality and adequacy (E2).

12. Ensure that the graphic presentations are presenting the information to the reader in an understandable manner (E2).

13. Consider if there are any key indicators that should be in the QA report every month. These might be high profile important outcomes that may (should) be of interest to senior management every month (E2).

14. Do not present individual clinical provider names and data in reports or presentations, such as the results of an individual physician's audit ratings (E2).

15. Organize and better manage the PITs, PETs, and committees (E2).

16. Create CAPs where appropriate and needed (E2).

17. Create graphs of CAPs data (E2).

18. Address the implementation and modification of CAPs (E4, E5).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions: Person Centered Training Curriculum o SGSSLC Section F Presentation Book o SGSSLC Self-Assessment o Q Construction Facilitation Monitoring Form o A sample of completed Section F audits done by SGSSLC o Data summary report on assessments submitted o Data summary report on team member participation at annual meetings. o A list of all ISP dates o ISP Draft for Individual #48 and Individual #127 o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, QDDP quarterly reviews: • Individual #379, Individual #207, Individual #132, Individual #50, Individual #38, Individual #99, Individual #174, Individual #130, Individual #60, Individual #215, and Individual #223. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Dana Robertson, Provision Coordinator o Mary Barrera, Acting Incident Management Coordinator o Jalown McCleery, Incident Management Coordinator o Michael Davila, QDDP Coordinator o Vanessa Barrientez, QDDP Educator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 12/2/12 and 12/3/12 o Unit 1 Morning Meeting o Administrative IDT Meeting o Annual IDT Meeting for Individual #48 and Individual #127 o Human Rights Committee Restraint Review Meeting 12/3/12 o QA/QI Committee Meeting

	Facility Self-Assessment: SGSSLC continued to use the self-assessment format it developed for the last review. It had been updated on 11/19/12 with recent activities and assessment outcomes. The QDDP Coordinator was responsible for the section F self-assessment. The facility added a number of activities to the self-assessment efforts in regards to section F. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed by the QDDP Coordinator, as well as other activities for each provision item. A newly formed mentoring team was responsible for attending ISP meetings monthly and commenting on the ISP development process. The facility was using information gathered from the mentoring team focus areas for training. The QDDP Coordinator was also observing ISP meetings and monitoring QDDP facilitation skills, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. For example, for F1d in regards to ensuring that assessment results were used to develop, implement, and revise the ISP, the QDDP Coordinator used the section F monitoring tool, along with the assessment tracking database and information obtained from the mentoring team regarding review of assessments at the ISP meeting to determine compliance. These are the same type of activities that the monitoring team looks at to assess compliance. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts to develop an accurate audit system and believes that the facility was continuing to proceed in the right direction. The QDDPs were recently trained on the new ISP process that was designed to meet the requirements of the Settlement Agreement. Moving forward, the facility can begin to assess the impact of that training. The facility self-rated itself as being out of compliance with all provision items in section F. The monitoring team agreed.
	Summary of Monitor's Assessment DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups that included state office and facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. SGSSLC QDDPs and many team members had been provided training on the new process by statewide consultants. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. SGSSLC had recently received training on the new process from state office consultants. The first IDT meeting held in the new format was during the week of the monitoring visit. Thus, the new ISP process had not yet been

	completed for any individuals at SGSSLC. The intention of limiting the monitoring teams' review to newer plans is to provide the state and facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement Agreement requirements. Since there were no written ISPs available that were representative of the new ISP process, this review was limited to data gathered through the facility's self-assessment process and limited observation of the new process. There had, however, been some positive steps forward with the new ISP process. • Two IDTs received training on the new ISP and integrated risk process from DADs consultants. • A mentoring program was implemented using department heads from various disciplines to attend ISP meetings and provide feedback to the IDTs on implementation of the new ISP process. • A new QDDP Educator was hired. • A new department had been established to write and train staff on all skill acquisition plans. The monitoring team observed two annual ISP meetings in the new format. Two IDTs at the facility had been selected to pilot the new ISP process which included the revised integrated risk process. The other IDTs were beginning to use the new ISP forms, but had not yet been fully trained on the new process. At the two meetings observed, the IDTs were following the format of the new ISP process and team members were holding a more integrated discussion. Team meetings were very lengthy and the IDTs were struggling with how to integrate the risk discussion into the ISP meeting. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings in the new format. The QDDP facilitated both meetings. Progress definitely continued to occur and was evident, with regard to the facilitation of meetings. • A much broader list of personal preferences was developed. • More efforts were made than in the past to elicit information from all team members. • There was an increase in the use of specific clinical data to support risk ratings. • The teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. • Teams were discussing action plans in more detail than in the past, particularly	Noncompliance

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		some of the strategies and supports that were in place or would be put in place. • There was much more careful consideration of how supports could be provided in a less restrictive setting. Both QDDPs had undergone additional training with a state office consultant on the new ISP format. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDP used this template to draft portions of the ISP prior to the meeting. The QDDP came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. Both meetings were good examples of facilitation that ensured that team members participated in the meeting and all topics were covered, but one ISP that we attended was 2.5 hours in length and the second was nearly five hours long. Individual #127 fell asleep before reaching the part of the meeting that he might have participated in. Perhaps the meeting could have been restructured to get his input. In both meetings, the risk discussion took a majority of the time. When teams become familiar with this process and more competent at assigning accurate risk ratings, this portion of the meeting should take much less time and more time can be spent on determining if supports in place are adequate and integrated throughout the individual's day. The QDDP Coordinator continued to monitor ISP meetings to evaluate QDDP competency with facilitation skills. At the time of the review, 32% of all QDDPs had been rated as competent in facilitation skills. 13% had not yet been evaluated. The new ISP monitoring tool was designed to assess QDDP facilitation skills, as well as, look at the overall discussion and quality of planning. This process was in the beginning stages of implementation and sufficient data were not yet available to be used to identify areas of concern. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to continue to develop facilitation skills that will allow them to ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed. The facility remained out of compliance with this provision item.	

#	Provision	Assessment of Status	Compliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004 described the Individual Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should have identified the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. The QDDP Coordinator had begun to track data on attendance at IDT meetings in July 2012. Participation by individuals at their IDT meetings averaged 85% for the three month period reported. Presence and participation by relevant team members averaged 72% over the three month period when data were collected. Participation by a dietician, day program staff and medical staff was found to be the lowest. The ISPs and ISPAs were not consistently attended by the therapy staff, though there had been a concerted effort to address this and improvements were noted. A checklist was developed to guide the therapists when in attendance at ISPs to ensure that specific PNM/therapy related issues were discussed by the IDT and included in the ISP document. This was only recently implemented. Although it is understandable that all disciplines will not be able to have a representative available for all IDT meetings, when input is critical from a particular discipline, the team needs to ensure that discipline is available for discussion with the IDT. At the two IDT meetings observed, a full range of staff from each discipline participated in the meeting. The state recently developed a new tool to assess personal preference and support needs. The Preferences and Strength Inventory (PSI) was similar to the PFA and should serve the same purpose in identifying preferences and support needs, which should be beneficial in determining what staff should be present at the annual IDT meeting. The facility had just begun using the PSI process to plan for the annual IDT meeting. A sample was not available for this review. A small sample of the most recent ISPs (in the previous format) provided to the monitoring team was reviewed for attendance at team meetings by key team members. • At the annual IDT for Individual #130, team members not present included her physician, dental staff, dietician, occupational therapist, or physical therapist. She had many complex health and support needs including being at risk for aspiration, choking, and polypharmacy. She had multiple diagnosis including hypercholesterolemia, hypertension, constipation, and GERD. • Individual #99's psychiatrist and dietician were not present for her annual IDT meeting, though the team acknowledged that she needed psychiatric and dietary supports.	Noncompliance

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		• The annual ISP for Individual #38 indicated that all key professional staff were in attendance at his IDT meeting, however, neither he nor his guardian attended the meeting. • Day program staff and active treatment staff were not present at the annual IDT meeting for individual #379. • Individual #60's signature sheet for his annual IDT meeting indicated that neither he nor his LAR attended his annual meeting. His day program staff, dietician, dental staff, physician, and physical therapist were also not present for the meeting. The psychiatry clinic forum was functioning, in a way, like a mini ISP, that is, a large number of staff were in attendance, the individual's QPMR was reviewed. Other than this, the lack of psychiatry staffing did not allow for the routine participation of psychiatry in other IDT processes or meetings. The facility was not yet in compliance with requirements for the IDT to accurately identify key team members and ensure input from those members into the ISP process.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. According to the new policy, the core IDT was to meet 90 days prior to the annual ISP meeting to identify what assessments needed to be completed based on the resident's preferences, strengths, needs, and risks, in addition to ICF/ID required assessments. IDT members were then directed to complete the recommended and required assessments and place them in the facility computer share drive for the IDT to review no later than 10 working days before the annual ISP meeting. Copies of the assessments were to be shared with the resident's LAR, family, actively involved person, or designated representative prior to the ISP meeting. The new process for completing and filing assessments had been implemented. The facility had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 4/1/12 through 9/30/12 indicated that assessments were not always submitted prior to ISP planning meetings. Occupational therapy, physical therapy, and nutritional assessments were submitted on time less than 50% of the time. The quality and timeliness of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's ISP, it is essential that adequate assessments be completed that identify	Noncompliance

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		the individual's preferences, strengths, and supports needed. Assessment quality and timeliness are addressed by the monitoring team throughout this report. Moreover, in section H1, the facility reported on the development of a new system to manage the timeliness and quality of assessments. The newer ISPs supported the facility's determination that assessments were not being submitted prior to annual ISP meetings in some cases. IDTs did not have adequate information needed to develop supports. For example, Individual #132's ISP noted that his PBSP and FAR were out of date and no longer reflected his functional ability at the time of the ISP meeting. The team did not have information needed at the time of his annual ISP meeting to develop critical supports. The state had recently developed a new tool to assess personal preference and support needs (and to replace the PFA). The facility had just begun using the Preferences and Strength Inventory (PSI). The PSI was similar to the PFA, but was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. Functional assessments were still not adequately addressing individual's preferences related to work, relationships, and community integration. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not yet in compliance with this item based on data available.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As described in F1c, assessments required to develop an appropriate ISP meeting were not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. QDDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. Recommendations resulting from these assessments need to be addressed in the ISPs either by incorporation, or by evidence that the IDT considered the recommendation and justified not incorporating it.	Noncompliance

#	Provision	Assessment of Status	Compliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	DADS Policy #004: Personal Support Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual ISP meeting, at minimum. The ADA and Olmstead Act require that individuals receive services in the most integrated setting to meet their specific needs. Training provided to the facility by DADS consultants included facilitating the living options discussion to include input from all team members. As part of the new ISP process, each discipline was asked to include, as part of the pre-ISP assessment process, a determination on whether or not needed supports could be provided in a less restrictive setting. Discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with, opinions offered by each discipline. Any barriers to community placement were to be addressed in the ISP. At the ISP observed for Individual #48, the team engaged in an interdisciplinary discussion regarding the least restrictive setting. She was currently living in a locked home. After much discussion, the team agreed that she could be safely supported in an unlocked home. It was agreed that she would be referred for more appropriate placement. Additionally, the team agreed that with the right supports, community living would be an option for her in the near future. The QDDP agreed to talk with her LAR about living options and schedule additional home tours in the community. The IDT did not develop action steps, however, that would promote increased integration into the community. The facility continued to struggle with developing ISPs that encouraged training in the community. For the most part, community based outcomes consisted of generic opportunities to visit in the community. When outing are planned specifically for greater exposure to the community, documentation should include a means to capture individual's preferences and interests. Those preferences and interest should be used to develop additional action steps that would encourage greater independence and integration into the community. Outcomes should be developed to address communication skills, decision making skills, social interaction, work and volunteer opportunities, and increased exposure to life outside of the facility. The facility self-assessment determined that this item was not yet in substantial compliance. The monitoring team agreed with this self-rating. Also see section T of this report.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that the Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the IDT "will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." In order to meet substantial compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. As noted in F1, additional opportunities to try new things should lead to the identification of additional preferences. Observation across the SGSSLC campus by the monitoring team did not support that individuals were spending a majority of their day engaged in activities based on their preferences. Opportunities to explore new interests and develop new skills were limited. The monitoring team observed very little meaningful day programming occurring. It was difficult to determine how most individuals were spending their day. The facility kept data on attendance, though it was still not clear who was held accountable for the lack of participation in day programs. This was noted to be a concern at the last monitoring visit. It was not evident that attendance had improved since the last review. Staff reported that refusals to attend day programming continued to be a problem. Poor attendance at the Suzie Crawford Center was attributed to staffing issues. There was improvement in some of the homes in offering active treatment opportunities based on preferences. Good interaction and engagement was observed in several homes, in other homes, individuals were spending a majority of their day in bed or sitting in chairs with very little staff interaction. The IDT for Individual #48 and Individual #127 developed a fairly comprehensive list of	Noncompliance

#	Provision	Assessment of Status	Compliance
		preferences and interests. Neither team discussed how those preferences and interests could be supported in the community. Individual #48 expressed a desire to live and work in the community. The IDT developed action steps to give her additional opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on her interests, or exploring volunteer opportunities. Many individuals in the sample described in section M had current annual ISPs that were completed in the newer, but soon to be revised, format. Most, however, failed to adequately incorporate the individuals' health problems, needs, and risks into their overall, annual plan and/or integrate their health and behavior needs into their plan for daily living and participation in work, leisure, community activities, etc. • For example, Individual #400 was a 20-year-old man with many psychosocial health problems and behavior problems. In addition, he was diagnosed with constipations, iron deficiency anemia, and tobacco addiction. His 8/9/12 annual ISP failed to accurately portray his health problems and risks, rather under the heading of "Health Concerns," it stated that he smokes, but does not present with pain, does not require pain management, does not require the use of pre-medical sedation and does not have any incurable medical conditions. Thus, for example, there were no planned interventions to address his constipation or his physician's recommendation to "try to persuade him to accept endoscopy," in order to evaluate his anemia. The facility was not in compliance with this item.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. Adequate data were not available for the monitoring team to determine compliance with this provision. As noted in past reviews, there was not a focus on identifying and addressing barriers to living in the most integrated setting. The facility had made little progress in developing measurable, meaningful training in the community. All individuals were offered opportunities to take trips in the community, but this still was not resulting in opportunities to integrate into the community. Work opportunities were limited to a few options based on contracts that the facility had for work in the onsite sheltered workshop. Little progress had been made on exploring community employment opportunities for individuals. The facility will need to assess whether or not IDTs are adequately identifying each individual's preferences, support needs, and barriers to living in a more integrated setting prior to assessing compliance with the requirements of F2a2.	Noncompliance

#	Provision	Assessment of Status	Compliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The outcome of the new ISP process should be a plan that integrates all protections, services and supports, treatment plans, and clinical care plans. The new ISP template included prompts to guide the IDT discussion and ensure that important information would not be omitted during the planning process. The development of action plans that integrate all services and supports was still an area that the facility was struggling with. State office established a workgroup to provide more guidance regarding action plan development. At both ISP meetings observed, the team spent more time trying to identify areas where measurable outcomes were needed, particularly in regards to risks. The teams engaged in more integrated discussion regarding support needs and preferences. This was a much better discussion than was observed during the last monitoring visit, though still an area where additional training is needed. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. Assessment recommendations need to be available when teams are developing action plans for training and interventions. In many cases, disciplines had developed treatment interventions and programs, but very few of these appeared to actually be a part of the ISP. The documentation for these was on a separate form and not considered a part of the ISP. For example, Individual #60 had a number of healthcare plans, a mealtime plan, and a PNMP referenced in his ISP, but the plans were not attached to his ISP and specific instructions were not included in the ISP. Action steps in the ISP stated to continue each plan without offering any further direction or guidance. When developing the ISP for an individual, the team should consider all recommendations from each discipline, along with the individual's preferences, and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. There was not a sample of new ISPs with action plans to review for compliance with this requirement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	IDTs will need to accurately identify needed supports and services through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings. The new ISP process should help teams more accurately identify needed supports. Additional training will be needed by IDTs to effectively integrate those supports into a comprehensive, functional ISP.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. ISPs in the new format will be reviewed for compliance during the next monitoring review. Also see section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will require that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services. Please refer to these sections of the report regarding the coordination of services as well as G1 regarding the coordination and integration of clinical services. As noted in F1b and F1c, adequate assessments were often not completed prior to the annual meetings. IDTs will need to work together to develop ISPs that coordinate all services and supports. Recommendations from various assessments should be integrated throughout the ISP. The facility did not have a process to ensure coordination of all components of the ISP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in 8 out of 10 (80%) records reviewed. The facility reported that 38 ISPs were filed more than 30 days after the annual ISP meeting in the past six months. The facility needs to ensure that plans are distributed and available to staff implementing the plan. More work needs to be done to ensure staff implementing plans are trained on the plan and understand why specific supports are needed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As the state continues to provide technical assistance in ISP development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	IDTs were no longer routinely holding quarterly review team meetings. Teams met to review any incidents, significant injuries, or changes in status immediately when determined necessary. A new monthly review form had recently been introduced. The QDDP Coordinator reported that QDDPs would now be completing a monthly review of services, supports, and outcomes for each individual. Each discipline was responsible for reviewing specific services and supports monthly. QDDPs were responsible for reviewing the overall plan. A coordinated system for monthly review of supports was not yet in place. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QDDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-	In order to meet the Settlement Agreement requirements with regard to competency based training, QDDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. • A review of training transcripts for 10 employees hired within the past year indicated that 10 (100%) had completed the new training on ISP process entitled Supporting Visions. All staff were required to attend an initial course on the ISP process. The facility was still waiting for additional training to be provided by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format. All departments will need to be involved in training staff on individual specific plans, such as healthcare plans, behavior support plans, PNMPs, and mealtime plans. An adequate monitoring system should be in place to ensure that all staff are familiar with plans and provide supports competently and consistently.	Noncompliance

#	Provision	Assessment of Status	Compliance
	based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	The facility did not have an adequate system in place to ensure ongoing training of individual specific plans.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current plans were available in 8 of 10 individual notebooks in the sample. Informal interviews with staff, however, indicated that not all staff were adequately trained on the requirements of individual ISPs. Familiarity with plans varied widely from home to home. Staff interviewed were generally aware of supports outlined in BSPs and PNMPs, but were not as comfortable discussing healthcare supports. The facility reported that 38 ISPs were filed more than 30 days after the annual ISP was held in the past six months. The facility needs to ensure that plans are distributed and available to staff implementing the plan. The facility was rated as being out of compliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings.	Noncompliance

Recommendations:

1. Team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year (F1).

2. It will be important for the QDDPs to develop facilitation skills that will allow them to ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed (F1a).

3. Efforts need to be made to ensure all team members are in attendance at IDT members in order to ensure adequate integration occurs during planning (F1b).

4. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

5. A description of each person's day along with needed supports identified by assessment should be included in ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

6. Provide additional training to IDT members on developing and implementing plans that focus on community integration. (F1e, F2a).

7. Outcomes should be developed to address communication, decision making skills, and increased exposure to life outside of the facility (F1e).

8. IDTs will need to identify each person's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

9. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The IDTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

10. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Specific behavioral indicators should be identified to determine successful attempts at outcomes (F2a2).

11. IDTs should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual (F2a3).

12. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs (F2a4, F2c).

13. IDTs should develop outcomes that are practical and functional at the facility and in community settings (F2a5).

14. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

15. Ensure plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation (F2c).

16. Develop a monthly review system adequate for determining the efficacy of all supports and services. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues (F2d).

17. Develop a process to revise ISPs when there is lack of progress towards ISP outcomes or when outcomes are completed or no longer appropriate, outside of scheduled monthly reviews. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

18. Develop an effective quality assurance system for monitoring ISPs (F2g).

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o SGSSLC Policy/Procedure: Off Campus Consultation Process, 7/26/12 o SGSSLC Policy/Procedure: Communication With Neurologist, 4/7/11, rev 8/25/11 o SGSSLC Policy/Procedure: Integrated Clinical Services and Minimum Common Elements of Clinical Care, 9/13/12 o SGSSSLC Section G Self-Assessment o SGSSLC Section G Action Plan o SGSSLC Provision Action Information o SGSSLC Sections G Presentation Book o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Medical Provider Meeting Notes o Administrative IDT meeting minutes o QI Council Meeting: Quality Assurance Reports 2012 o Review of records listed in other sections of this report Interviews and Meetings Held: o Scott Lindsey, APRN, Medical Administrative Director o Lisa Owen, RN, QA Nurse o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Dental Clinic o Psychiatry clinics o Daily medical meeting

	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the two provision items, a series of activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. For G1, all of the activities reviewed centered around attendance in the various meetings held at the facility. The self-assessment documented that improvement was needed in attendance at several of the meetings reviewed. There was no measure to determine if services were ultimately delivered in an integrated manner. There were no data available for G2. In moving forward, the monitoring team recommends that the facility review this report. For each provision item in this report, the facility lead should note the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in noncompliance with both provision items. The monitoring team agrees with the facility's self rating.
	Summary of Monitor's Assessment: The facility made some progress in this area. It appeared that provisions G and H had been united with much of the emphasis for this review placed on Provision H. A single policy was developed for both provisions, but the policy clearly focused on section H. The weekly administrative IDT meeting also occasionally covered section G in addition to section H. The medical administrative director served as the lead for this section G as well as section L. With the many tasks related to reorganizing the medical department, a singular focus on this provision would not be expected. During each monitoring visit, the monitoring team conducts a meeting with the facility staff to discuss integration of clinical services and the minimum common elements of clinical care. The monitoring team met with the medical administrative director and QA nurse to discuss the facility's continued efforts in integrating clinical services. Through this meeting, the monitoring team learned that a great deal of collaboration occurred between the section G and H leads and the medical compliance nurse in the development of the facility's policy. Throughout the week of the review, the monitoring team encountered examples of integrated clinical services. Areas where integration was needed, but failed to be evident, were also noted. Continued work in this area is needed.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The facility developed a policy, Integrated Clinical Services and Minimum Common Element of Clinical Care, intended to guide this provision. The policy emphasized the minimum common elements, but did discuss some of the guidelines used by the facility in the provision of clinical services. The policy did not highlight how the various disciplines came together to provide services in an integrated manner, so the monitoring team asked during its usual meeting with facility staff if some examples could be provided. Examples provided included: • The daily clinical services meeting • The collaborative work done to complete the policy for provisions G and H • Bowel management – The medical administrative director specifically described how he interacted with direct care professionals, home nurses, and nurse case managers to assess individuals who were reported to have constipation issues. Through interviews, observations of activities, review of records and data, the monitoring team saw many good examples of integration of clinical services. The following are examples of integration that were noted: • The daily medical provider meetings continued to serve as a means for staff to discuss information regarding the past 24-hours including hospitalizations, emergency department visits, infirmary reports, etc. The medical director facilitated the meetings, which now also included discussions about completed and scheduled consultations. • Collaboration between dental clinic and psychology improved. The dental documentation frequently noted that a psychologist was in clinic to assess an individual who had difficulty tolerating dental treatment. This assessment was used to determine the strategies and/or treatment that would be used to overcome the barriers to treatment. • A new pretreatment sedation process was developed, but had not been implemented. This process would involve review of sedation by the medical provider, pharmacist, and psychiatrist (when indicated). • The nursing and medical departments met weekly to address interdepartmental problems and concerns. For example, during the onsite review, the monitoring team attended the weekly meeting, which included integrated reviews and discussions of the use of restraint, availability/accessibility of individuals' records, individuals in need of EKGs, and plans to address the issues discussed via a "Weekly To-Do List." Also, since the prior review, two of the facility's IDTs were trained on how to conduct integrated risk assessment and planning meetings to address their health needs and risks. • There was integration with the medical staff and other disciplines, such as nursing, psychiatry, and dental via the medical provider meeting.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Integration of psychology and psychiatry was good. Psychologists and psychiatrists appeared to have meaningful interactions during psychiatry clinic. • The PNMT met consistently with the IDTs to review their findings and to participate in the risk assessments for individuals they had reviewed or assessed. An SLP attended the Behavior Support Committee meetings to ensure that communication strategies were accurately integrated into the BSPs. • The monitoring team also attended several committee meetings that were multidisciplinary and could, therefore, assist in delivering services in an integrated manner. Several areas offered great opportunities for improvement: • The pharmacy department struggled to deliver its services in an integrated manner. Throughout the week of the review, it was evident that the department suffered numerous disconnects with the medical, nursing, and psychiatry departments that impacted the delivery of care and how pharmacy services integrated with those clinical areas. • Although the neurology consult forms now included an additional section for input by the psychiatrist, it was not clear that this would be an effective means to achieve adequate integration of neurology and psychiatry services. • During the onsite review, the facility administration reported to the monitoring team that two individuals – Individual #127 and Individual #48 – had undergone application of the revised version of integrated risk rating assessment and integrated health care planning process. Thus, the monitoring team requested these individuals' records for review. Remarkably, neither record revealed evidence of implementation of the aforementioned processes. For example, the one individual's comprehensive nursing assessment was not current, the other individual had not received a comprehensive nursing assessment for over one year, both assessments failed to completely reference significant changes in the individuals' health status since the prior assessment, and neither resulted in a complete list of the individuals' nursing problems/diagnoses. Thus, neither of the individuals' records had a complete, current IHCP. • The review of 21 sample individuals' records (listed in section M) revealed that more than three-fourths had a pattern of problems ensuring that individuals received integrated clinical services to meet their needs. • A glaring deficit that continued to be seen in this review was between medical and nursing. Record reviews continued to show that individuals experienced health problems and received treatment without physician notification. At other times, medical providers received inadequate information, such as not being notified that an individual with fever received Clozaril, which had the ability to suppress the immune system.	

#	Provision	Assessment of Status	Compliance
		• Psychology and psychiatry had not succeeded in ways of enhancing integration of clinical services, such as cohesive case formulations. There continued to be deficits with regard to establishing an evidence-base approach of determining the efficacy of the medication regimen (i.e., irrelevant data collection concerning psychiatric target symptoms).	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	Several positive changes were made in the consultation process. The consultation referral form was revised in July 2012. The front of the form now included a section to indicate attachment of the MOSES and DISCUS evaluations, history and physical, labs, seizure records, and other information. The back of the form was utilized by the facility providers to document review of the consult. Information documented on the reverse of the form included: • Acceptance or rejection of recommendations • Explanations or plan of care • Change in status requiring formal IDT review • Signatures of PCP, psychiatrist, RN case manager • Ready to file The form had been implemented at the time of the review, but its use was not consistent. Some providers utilized the explanations and plans of care on the form in lieu of an IPN entry, however, this was problematic because the Health Care Guidelines required documentation of the consult in the IPN. The medical department continued to utilize the consult stamp to track lab studies. In order to review compliance with requirements of the Health Care Guidelines, the monitoring team requested that both the front and back copies of all consultations were provided. This was not consistently done which significantly decreased the sample size of consultations available for review. The consults and IPNs for five individuals were requested. A total of 45 consults completed after May 2012 (including those from the record sample) were reviewed: • 24 of 45 (53%) consultations were summarized by the medical providers in the IPN within five working days. Overall, the medical providers did a very good job summarizing the recommendations of the consultants and stating agreement or disagreement with the recommendations. In some cases, there were explanations stating the consultant would be contacted for clarification prior to making a decision. Other notes stated that issues needed to be referred to the IDT for discussion. The following is an example of how the information from the external consultant was positively communicated and integrated into the individual's supports.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #104's record referenced communication between his SGSSLC physician and his non-facility physician and between his RN case manager and his non-facility SLP. The physicians discussed his case and his diagnosis of aspiration pneumonia, and addressed his SGSSLC's physician concern regarding his high bicarbonate blood level. The SLP and the RN case manager discussed his ability to tolerate a fluoroscopy study to evaluate his aspiration and his tolerance of his present diet. These discussions resulted in a collaborative decision to forego the fluoroscopy, continue his present diet, and continue his current home medications, such as Albuterol inhaler, to help his lung function/respiratory status. The barrier to compliance with this requirement was related to timelines with IPN documentation rather than content of the entries. This may have been related to problems with routing and filing.	

Recommendations:

1. The facility will need to address the deficits noted regarding integration including those related to pharmacy, neurology, psychiatry, medical and nursing (G1).

2. The facility should ensure that committees are functioning as stated in policy with the required participants (G1).

3. The facility needs to develop a system to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).

4. The facility needs a mechanism to track all consultations and appointments for diagnostics. Consideration should be given to using a format that will allow sorting by multiple fields including specialty, individual, appointment date, and PCP (G2).

5. In accordance with the Health Care Guidelines, for each consultation, the IPN entry should include documentation of the recommendations of the consultant, a statement regarding agreement or disagreement, and a decision about referral to the IDT. The primary providers should also indicate the specific consult that is being addressed.

6. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

7. The facility should ensure that consults are obtained in a timely manner. Adding a priority level (within seven days, 21 days, etc.) to the database may be helpful in achieving this regard (G2).

8. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Interviews and Meetings Held: o Lisa Owen, RN, QA Nurse o Scott Lindsey, APRN, Medical Administrative Director o Albert Fierro, RN Medical Compliance Nurse o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Dental Clinic o Psychiatry clinics o Daily medical meeting/Medical rounds
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions (provision action information). For the self-assessment, the facility described for each of the seven provision items, a series of activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. For this provision, the self-assessment aligned with the information contained in the November 2012 Minimum Common Elements of Clinical Care Report. For each discipline, data were provided on the elements identified by the facility. During the week of the onsite review, the monitoring team met with facility staff to discuss the self-assessment, the November 2012 report, and the provision. The monitoring team also attended the administrative IDT meeting where the report was presented. In moving forward, the monitoring team recommends that the facility lead follow guidance from state office provided in the form of policy issuance or otherwise. Moreover, the facility lead should review, for each provision item in this report, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. The facility found itself in noncompliance with all seven provision items. The monitoring team agreed with the facility's self rating for six of the seven. The monitoring team found substantial compliance with provision H2.

	Summary of Monitor's Assessment: The facility's QA Nurse continued to serve as the center's lead for section H. This provision appeared to move from relative obscurity to the forefront of the thoughts of the clinical department heads. Throughout the week of the compliance review, the monitoring team heard many anecdotal accounts of the development of the section G and H policy and how staff worked to move towards compliance with the Settlement Agreement for section H. It appeared that the efforts for section H were very much efforts for section G as well. The progress seen in this section was also a lesson on how a section or project can gain momentum when placed under the direction of the appropriate individual. The center's lead should be commended for the work done in this provision. During the week of the onsite visit, the monitoring team had the opportunity to meet with the QA nurse and the medical administrative director, who served as the section G lead, to discuss the work done in this area. There had been significant collaboration between them along with the medical compliance nurse. The section H lead used the presentation book and November 2012 report to explain the status of section H. She explained that the facility proceeded with this provision by defining the core clinical services: communication, habilitation, physical and nutrition management, nursing, medical, psychiatry, dental, pharmacy, and psychology. Each clinical discipline was responsible for conducting required audits and reflecting that information within their departmental data summaries that were submitted for the QA Benchmark Meetings. An audit tool was developed for each clinical service to validate that the required services were provided, monitored, and documented within the data summaries. A comprehensive policy was developed to guide these efforts. The policy was a collaborative effort of the facility's APRN, QA nurse, and medical compliance nurse. The policy specified many standards of care and established the framework for how clinical services -health care- was delivered in the facility. Yet, it was apparently developed or prepared with no significant input by the facility's medical director, which the monitoring team thought unusual. The policy covered several topics including (1) assessments and evaluations, (2) diagnoses, (3) treatments and interventions, (4) training and education, (5) clinical indicators, (6) system to monitoring health status, (7) treatments and interventions modified in response to clinical indicators, and (8) integrated clinical services. Thus, for each provision item, each discipline was expected to address the requirements of the provision, monitor the services, and provide documentation that this was done. This was achieved to variable degrees of success for the different departments. This report will provide information on the facility's efforts to implement the process outlined in the policy. It will also provide as usual, the findings on the monitoring team with regards to each provision item. Throughout this report, references are made to the November 2012 Minimum Common Elements of Clinical CRE Report (MCER). The monitoring team was also provided a presentation book, which contained additional information, much of which was informative and very helpful. The monitoring team was also

	provided with a voluminous amount of emails, which often were simply requests for data for information. The inclusion of such communication and multiple examples of documents resulted in a document of 1200 pages. In the end, the over-inclusion of emails and communications limited the usefulness of the presentation book. To that end, the monitoring team primarily utilized the data found in the 30-page November 2012 report.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>H1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.</td><td>A lengthy list of scheduled and interval assessments were included in the facility policy. The monitoring team, however, noted the absence of the important interval sick call medical assessment for acute medical illnesses. The timeliness of these evaluations was worthy of appropriate monitoring.

The MCER identified three elements for analysis specific to provision item H1 that were captured in the audit tool:
Timelines for completing of scheduled assessments
The appropriateness of interval assessments in response to changes in status
Quality of assessments that will capture compliance with acceptable standards of practice
Data collected by the clinical disciplines and reported in the Benchmark Meeting is summarized in the table below.

<table>
<tr><td colspan="10">Assessment Compliance 2012 (%)</td></tr>
<tr><td></td><td>Sect O</td><td>Sect P</td><td>Sect R</td><td>Sect M</td><td>Sect L</td><td>Sect J</td><td>Sect K</td><td>Sect Q</td><td>Sect N</td></tr>
<tr><td>Oct</td><td>0</td><td>100</td><td>83</td><td>15</td><td>9</td><td>--</td><td>40</td><td>80</td><td>--</td></tr>
<tr><td>Nov</td><td>100</td><td>100</td><td>83</td><td>23</td><td>9</td><td>--</td><td>40</td><td>100</td><td>--</td></tr>
</table>

The facility report noted that the graph accompanying this chart represented the cumulative score for each individual discipline for all elements noted under H1 for November 2012.

The narrative of the MCER cited problems related to a lack of information on interval assessments for some disciplines and lack of quality indictors. With some areas failing to even report data, it was known that additional work was needed in the area of assessments. The monitoring team would like to point out that each of these elements would need to be scored independently.

In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, and reviewed assessments and facility data. This report contains, in the various sections, information on the required assessments. The results of those activities are summarized here:</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		• Annual Medical Assessments were found in all of the records in the record sample. The overall compliance with timely completion (365 days since previous assessment for the sample reported in section L) was 60%. The quality of the annual assessment is discussed in section L1. • Quarterly Medical Summaries were not being completed by the medical staff. A template was developed, but had not been implemented at the time of the review. Given the current staffing, the plan was to begin with semi-annual summaries and progress towards the requirement of quarterly completion when staffing was increased. • QDRRs were current in only one of 10 records of the record sample. Additional documentation showed that 155 of 221 (70%) individuals did not have current QDRRs as of 12/7/12. Documentation and record reviews showed that no QDRRs had been completed after September 2012. This is discussed in further detail in section N2. • Annual Dental Examinations were being complemented in a relatively timely manner. A compliance of 20% in October 2012 lowered the facility's overall compliance to 80%. • Regularly scheduled quarterly and annual nursing assessments were either significantly delayed and/or missing in 17 of the 21 records reviewed. For many of the individuals, assessments were delayed six-plus months, and for a number of these individuals, the failure to have current, comprehensive; nursing assessments completed and filed in their records jeopardized their health and safety. • This was a significant decline in performance and compliance with the provisions of M2. In addition, a review of the individuals' nursing assessments, which were filed in the records, revealed that there were no substantive improvements in the nursing assessments. All assessments, except the assessments for one individual, failed to provide one or more components of a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. • There was a lack of timeliness in the completion of QPMRs where individuals were not evaluated by a psychiatrist within a 90-day period this reporting period. The facility did not tabulate specific data to calculate the percentage or number of individuals that warranted a follow-up (i.e., quarterly) psychiatric evaluation. • The facility had 135 individuals who still required a comprehensive psychiatric assessment as described in Appendix B. At this rate, it would take approximately 4.0 years to complete all of them, without any new admissions to the facility.	

#	Provision	Assessment of Status	Compliance
		• Only 16 of 38 individuals (42%) had communication assessments completed on or before the due date listed in the tracking log of assessments completed since the previous review by the monitoring team. There was a Master Plan to prioritize these, but the progress with this was slow. Approximately only 16% of the assessments reviewed completed 10 days prior to the ISP date identified in the assessment. Two were completed more than 45 days prior to the ISP, and in these cases, an update would be required (Individual #66 and Individual #40). There were six completed after the ISP and five with no current assessment associated with the ISPs submitted. A number of the individuals reviewed for section P had current comprehensive OT/PT assessments, though not all. • Not everyone had an initial psychological assessment. • Functional assessments were not completed for all individuals with PBSPs. Annual psychological assessments were not completed for all individuals. The purpose of this provision is for the facility to manage its required assessments. However, it was not clear how the facility used these data. For example, the self-assessment indicated that the pharmacy department submitted no data for the months of August 2012 and September 2012. As discussed above, the compliance with QDRR completion was dismal and the lack of data reporting may have been a leading indicator of this. Similarly, psychiatry failed to report data. Again, that department had significant assessment deficits. These assessments provide information required for clinical care and at some point warranted major corrective actions. The November 2012 reports provided no insight on corrective actions of that nature.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The facility identified the elements cited in the Settlement Agreement and added additional items, including the requirement to have the diagnosis recorded correctly in all locations, including the APL, psychiatry reports, and annual assessment. An additional requirement included formulation of diagnoses by psychology and psychiatry as a team. Nursing elements were also added, such as do the nursing diagnosis clinically fit the corresponding assessment. The facility had no data to assess this area. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. • There was an improvement in the content of the completion of the Appendix B comprehensive evaluations consistent with the current version of the DSM-IV-TR. • Additionally, the psychiatry department updated the policy and procedure for psychiatric services and nicely outlined a new psychiatric format to be utilized for the assessments that included a diagnostics section	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• Across the majority of the 21 sample individuals' reviewed, the conclusions (i.e., nursing diagnoses) drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks and failed to result in complete lists of nursing diagnoses, in accordance with standards of practice. For example, Individual #314's nursing assessment failed to reference his responses to his actual health problems, such as diabetes, thalassemia minor, constipation, lactose intolerance, etc., as well as his potential health problems related to his cigarette smoking.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The facility identified elements for analysis, including preventive care screenings, immunizations, timeliness of treatment and interventions, clinical outcomes, medical audits, staffing, equipment, death rates, and morbidity. For this provision item, the November 2012 MCER presented extensive data on the two most recent internal and external medical provider audits. The monitoring team has commented extensively on the medical provider audits in previous reports as well as in section L2 of this report. Most comments have focused on the need of the audits to include an appropriate balance of indicators, specifically the need to measure the clinical outcomes experienced by the individuals at the facility. The current iteration of the tools, including the medical management audit tools, measured processes, but did not capture clinical outcomes. The lack of measurable clinical outcomes was aptly noted in the MCER. The monitoring team offers the following comments regarding the timeliness of treatments and interventions based on observations, document and record reviews: • As noted in all prior reports, the absence of complete nursing diagnoses was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. Thus, the majority of the individuals reviewed failed to have HMPs that referenced specific, individualized nursing interventions developed to address all of their care needs, including their needs associated with their health risks. o Of note, the process of health care planning was slated to change. At the time of the review, SGSSLC had just begun its implementation of the state's integrated health care planning process. • As noted in H1, assessments were not timely. Examples are provided throughout section J regarding that lack of indications for medication use. The facility utilized the incorrect definition of polypharmacy. The facility utilized polypharmacy and lacked an accurate definition of polypharmacy. The IDT and psychiatric practice were geared towards individuals receiving medication for aggression towards others and SIB, but was not focused on psychiatric symptoms associated with DSM-IV-TR diagnostics.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• There remained a need to enhance both the identification and implementation of non-pharmacological interventions. • The interventions provided by Habilitation Therapies were generally functional and appropriate, but there were not consistent baselines or measurable objectives established for each of these to make decisions related to continuation, modification or termination of direct therapy.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The facility identified a list of clinical indicators that included structural, process, and outcome indicators. Among the indicators included were preventive care guidelines, polypharmacy, diabetes, UTI, and immunization rates. It was also documented that the medical department was tracking diagnoses, preventive screenings, active problem lists, and labs. The section lead detailed in the MCER that some discipline heads submitted partial listings of clinical indicators. Overall, the facility received a 25% compliance score for this provision item. This score represented a cumulative score for audited items present on each clinical discipline's data summaries for the month of November 2012. The monitoring team found the following with regards to this provision item: • The medical department had not established a comprehensive set of clinical indicators. Data were collected on several preventive screenings and several disease conditions. Internal and external medical audits were completed. Medical management audits were added over one year ago to address the lack of outcome focus of the general audits, but the medical management audits all remained centered on processes. • Across all records reviewed, the clinical justification for the goals/indicators of the efficacy of treatments were unclear. For example, some individuals had goals that indicated that they would suffer less untoward outcome(s) than they suffered over the past year, and most individuals had goals that indicated that they would not suffer an untoward outcome over the next year. It was clear that the individuals' teams would continue to benefit from additional training and support regarding outcome identification, measurement, and evaluation. This was probably one of the individuals' most relevant aspects of planning, but the least attended to during the planning processes. • The collaboration between psychology and psychiatry regarding the selection of clinical indicators focused predominantly on maladaptive behaviors as opposed to evidence-based reasons to determine the efficacy of the medication. Polypharmacy will not be successfully minimized if medications were only prescribed for behavioral challenges that may have been the result of environmental antecedents as opposed to symptoms of a psychiatric disorder. • The inconsistency of documentation did not reflect routine review of status or progress specifically related to the goals and progress. In a number of cases, the	Noncompliance

#	Provision	Assessment of Status	Compliance
		justification for changing or terminating the interventions were not well documented. • The outcomes established by the PNMT for individuals they had assessed were generally measurable. Specific criteria for review was clearly established and as a result, reviewed and tracked in a manner that permitted comparative tracking of progress or change (weight data, for example).	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Each clinical discipline was responsible for identifying what systems were in place to monitor services as well as what data would be used to monitoring the health status of the individual. For psychology, PNM, habilitation, and communication services, data related to appointments, consultation, and recommendations were tracked. Nursing services followed assessments, management plans, outcomes, and appointments. Medical services tracked preventive care, and disease conditions, such as pneumonia, UTIs, constipation, osteoporosis, and diabetes. The report listed analysis of mortality data and appointment data by the medical department. The monitoring team noted the following: • The medical department was collecting data and entering it into a database. Data were used to ensure that screenings were done, but the medical staff themselves acknowledged that they had not arrived at the point of conducting any sort of data analysis. The medical department did not have data related to clinical appointments nor was it conducting analysis of morality data. • As of the review, there were no systems that effectively monitored the health status of individuals that were being consistently implemented at SGSSLC. Although the nursing assessment process vis a vis implementation of the assessment and reporting protocols and conduct of acute, quarterly, and annual assessments, would/could serve as such systems, there was no evidence that it was implemented, partially or otherwise. Thus, health plans (acute and chronic), which were in place for days, weeks, months, and even years, were not adequately reviewed/revised and modified to meet the individuals' needs and the changes in their health status and risks. • The psychiatrist attended meetings with the primary care physicians and other medical staff inclusive of nursing. The psychiatrist ordered laboratory monitoring, EKGs, and cited all medications prescribed, not only the psychotropic medications. Additionally, the psychiatrist outlined the medical illness specific for each individual in Axis III. The PCP reviewed the health status of the individual and summarized findings in several documents, including the annual physician assessment. The psychiatrist did not regularly establish a risk-benefit analysis for each individual receiving psychotropic medication. The nursing staff was available during psychiatric clinics and provided a review of	Noncompliance

#	Provision	Assessment of Status	Compliance
		health status findings to the psychiatrist. There was deficiency in the timely administration of the standard assessment tools for monitoring, detecting, reporting, and responding to side effects of the psychotropic medication based on the individual's current status. There was lack of reporting of ADRs. Developing a system to monitor the health status of individuals is complex due to the multilayered nature of the process. It will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The facility will need to expand the set of clinical indictors to define what is important to the individuals and what is important for the facility to monitor. The monitoring team noted the absence of outcomes, such as SIB and choking, on the indictors list. These would be important to track. While it was good to see that the facility was defining clinical indicators, the monitoring team did not grasp the facility's vision for an overarching plan on how these indicators would be monitored. None of the processes, such as the Benchmark Meetings or the QI Council, would have the depth to adequately monitor what is essentially a health care quality/risk management process. The monitoring team will use a simple example of osteoporosis as an example of the multiple layers that are needed in monitoring health status from risk assessment to clinical care and oversight of clinical care. In the case of osteoporosis, an individual's risk assessment might indicate a risk for loss of bone density. Providers would determine how to reduce risks. Perhaps the individual received medications, such as corticosteroids or AEDs, that increased risk, but those medications could be limited in order to mitigate risks. An appropriate screening would be done. If the individuals required pharmacologic therapy due to the diagnosis of osteoporosis, there would be periodic and routine assessments by medical, nursing, and therapists to determine if treatment was effective or if side effects developed. Therapy would be altered based on the results (e.g., changes in periodic DEXAs, vitamin D levels). If the individual experienced acute problems, medical, nursing, and therapies staff would evaluate the individual and the physician would formulate a diagnosis and treatment plan in conjunction with the IDT. At the end of the spectrum, the medical quality program would periodically review data to determine if this individual and others received appropriate therapy. Should the individual sustain a fracture, there might be a review by and additional oversight or medical risk management process to determine if care was appropriate or environmental factors influenced the outcome. Interspersed in these activities are the clinical pathways that provided guidance on treatment and assessment of the outcomes.	

#	Provision	Assessment of Status	Compliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The facility determined that each clinical discipline would identify that when clinical indicator data suggested unacceptable results, the current treatment plan would be altered as evidenced by additional assessments, diagnostics or modified therapeutic regimen. Moreover, each discipline was to document how clinical indicators analyzed structures processes and outcomes. In the case of medical services, the medical QA audits were to identify structures, processes, and outcomes. Nursing services cited the rates of hospital admits, readmits, acute interventions for bowel management, prevalence for dehydration, prevalence of undesired weight loss, and others. Psychiatry identified monitoring of suspected ADRs. Pharmacy noted documentation of plans of correction for deficiencies found in pharmacy surveys and collaboration with prescribers in monitoring ADRs. The total score for this provision was six percent, which represented a cumulative score for audited items present in each disciplines data summaries. The monitoring team observed: • There was little evidence that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes resulted in revisions to their HMPs. For example, individuals with plans to address their morbid obesity were not modified in response to their failure to lose weight and, in a number of instances, when they actually gained weight, individuals with plans to address risk for alteration in skin integrity were not modified in response to episodes of skin breakdown, individuals with plans to address their risk for injury related to falls were not modified despite falls with injuries, individuals with plans to address an acute head injury were not modified to address repetitive head injuries, and individuals with plans to address the risk of side effects of their medications, especially psychotropic medications, were not modified in response to episodes of adverse reaction(s) to medication(s). • As stated in H4, the lack of desired response usually resulted in an increase in medication to target behavioral challenges.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the	The facility required each clinical discipline to document how integration was achieved either through the department or clinical committee. The facility had an overall score of 56% for November 2012. The monitoring team would like to suggest that the suggestion that committee participation results in integration of services be de-emphasized. Multidisciplinary committees set a framework for the manner in which services may be delivered in an	Noncompliance

#	Provision	Assessment of Status	Compliance
	provisions of Section H.	integrated manner. The facility needs to focus on the actual outcomes of delivery. For example, how often did the case manager or another facility nurse conduct rounds with the medical staff, to provide real time data to the medical staff about the status of the individual that could help the provider make a clinical decision and impact the outcome. Does the clinical pharmacist meet with the medical provider and have a discussion regarding potential drug interactions or abnormal findings that impact the individual? The psychologist who spends a day in the dental clinic working with the hygienist and the dentist by helping to conduct assessments to determine the problems that individuals have upon arrival to dental clinic is helping to deliver services in an integrated manner. These actually definable moments should be noted.	

Recommendations:

1. The facility must ensure the following with regards to assessments:
    a. The facility must ensure that discipline audit tools are capturing the appropriate discipline specific standards of care (H1)
    b. The facility must be able to demonstrate that corrective actions have been implemented for those areas that have deficiencies related to assessments (H1).

2. The facility must continue develop a comprehensive list of clinical indicators across all clinical disciplines. (H3, H4).

3. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

4. Provide all staff with the copies of the applicable clinical guidelines, protocols, policies, and procedures, ensure that training has been completed, and hold staff accountable for use (H4, H6).

5. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition (H2).

6. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes / what the provider did for the individual and how well it was done and (2) outcomes / the state of health that follow care (and may be affected by health care) (H3, H4).

7. The facility must have a system that regularly reviews clinical guidelines, protocols and selected indicators to ensure that current practices are implemented and the most relevant indicators are being measured (H3, H4).

8. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

9. Corrective actions should also be implemented for departments that fail to submit data (H1 – H7).

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o DADS SSLC Risk Guidelines dated 4/17/12 o List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year o List of all choking incidents o List of individual at risk for aspiration o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individual with contractures o List of individual with GERD o List of individuals at risk for choking o Individuals with a diagnosis of dysphagia o List of individuals at risk for falls o List of individuals at risk for weight issues o List of individuals at risk for skin breakdown o List of individuals at risk for harm to self or others o List of individuals at risk for constipation o List of individuals with a pica diagnosis o List of individual at risk for metabolic syndrome o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for dehydration o List of individuals who are non-ambulatory o List of individual who need mealtime assistance o List of individuals at risk for dental issues o List of individual receiving enteral feedings. o List of individuals with chronic pain. o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #60, Individual #215, Individual #223, Individual #379, Individual #207, Individual #132, Individual #50, Individual #38, Individual #99, Individual #174, and Individual #130.

	Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Vicki Hinojos, Residential Director o Angela Garner, CNE o Dena Johnston, Director of Rehabilitation o Mary Barrera, Acting Incident Management Coordinator o Jalown McCleery, Incident Management Coordinator o Michael Davila, QDDP Coordinator o Vanessa Barrientez, QDDP Educator Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 12/2/12 and 12/3/12 o Unit 1 Morning Meeting o Administrative IDT Meeting o Annual IDT Meeting for Individual #48 and Individual #127 o Human Rights Committee Restraint Review Meeting 12/3/12 o QA/QI Committee Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment. It was updated on 11/19/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting the requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. Findings from the self-assessment had also been compiled for the facility QA report with a summary of findings from the section I leader. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. For each section, the facility reviewed a monthly sample using the section I audit tool, reviewed the ISP Monitoring Tool data, and reviewed data collected on assessment submission prior to the ISP meeting. Data collected from the section I audit tool indicated a higher compliance rating then what the monitoring team found. The section lead noted that staff completing the tool may not have used the same criteria for determining the quality of risk assessments and plans as the monitoring team did. Additional training was

	being provided on completing the audit tool. The facility recognized that the risk process was a very new process for the IDTs and it would take some time to develop an adequate system for addressing risks. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed. As the facility gains a better understanding of the risk process, it will be important for the audit process to evaluate quality and efficacy of risk assessments and plans.
	Summary of Monitor's Assessment: While progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in section I. Adequate plans were not yet in place to address all risks. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Some of the changes included regrouping the Risk Guidelines, so that the risk factors that were clinically related were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually. Consultants from the state office recently provided training to select department heads and IDTs. Two IDTs had been trained on the new process. The monitoring team had a chance to observe both teams hold meetings utilizing the new format. Team meetings were very lengthy and the IDTs were struggling with how to integrate the risk discussion into the ISP meeting. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process. Facility wide training on the new risk process was scheduled for January 2013. The facility had appointed the Director of Residential Services as lead for section I. It was clear that the facility was taking an integrated approach to developing an adequate risk process. Several key department heads were working together to ensure implementation of the new process. The newly created ISP mentoring team members were evaluating progress with section I requirements using the ISP monitoring tool. As noted in section F, assessments were not being consistently completed prior to ISP meetings. Teams could not adequately discuss risk factors without current, accurate assessments in place. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Teams were often waiting until a critical incident occurred before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm.

	It will be important for the facility to review incident and injury trends to identify systemic issues that place individuals at risk. In some instances, the facility will need to address systemic issues on a broader scale to reduce these risks. For example, behavioral incidents leading to peer-to-peer aggression places many individuals at the facility at risk for injuries. Similarly, the high number of sexual incidents at the facility places individuals at risk for acquiring a sexually transmitted disease. Some problem areas that contribute to these incidents are adequate supervision and meaningful engagement. The incident management team should work closely with IDTs to identify risk related to incidents and injuries and ensure appropriate protections are implemented, monitored, and evaluated for efficacy.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT meeting and the team was required to develop an integrated health care plan to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee when appropriate. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Changes that included regrouping the Risk Guidelines, so that the risk factors that were clinically related (regarding outcomes or provision of services and supports) were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Seven groupings of risk categories were identified. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers, and criteria for IDT review. Updates in status were to be noted on the form, making it easier to track status and determine when the team had met to discuss changes in status. The Risk Action Plans for the identified high and medium risk indicators were to be replaced with Integrated Health Care Plans (IHCP) designed to provide a comprehensive plan that will be completed annually and updated as needed. The state office hired a team of consultants to work with facilities on developing person-centered support plans. This was to include a risk identification process that would result in one comprehensive plan to address all support needs identified by the IDT. The risk identification process had undergone several revisions in the past year. The consultants had recently provided training and technical assistance to two IDTs at	Noncompliance

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		SGSSLC on the latest revisions in the risk process. The monitoring team was able to observe two IDT meetings using the new style ISP format and new risk rating forms. Progress towards developing an effective process to identify risks was observed in both meetings. Both IDTs followed the newly created IRRF. At the ISP meeting observed for Individual #48, the team spent a considerable amount of time reviewing each risk category, determining an appropriate risk rating, and developing action plans to address her risks. The team included the individual in the discussion and development of action plans. For example, the dentist reported that she was at risk for dental disease due to appointment refusals. She agreed that she would go to her next appointment if it was scheduled in the afternoon. It was very positive to see the IDT take time to ensure that she understood her risks and that they included her in developing strategies to reduce her risk levels. Overall, the team engaged in good discussion and assigned appropriate risk levels for each category. There was still quite a bit of uncertainty over the assignment of risk levels and team members were trying to understand how to use assessment criteria to make risk determinations. At the annual ISP meeting for Individual #127, the team also used the new IRRF to determine risk levels in each category. The risk discussion was very lengthy with much deliberation for each risk area. Team members appeared comfortable adding to the discussion and debating risk levels. Again, it was evident that the IDT was not entirely comfortable with the process and clear on what the outcome should be. At both IDTs observed, team members came to the meeting much better prepared to discuss risks and took a much more integrated approach to assigning risk levels. While much progress had been made in the risk process, additional training is still needed to ensure that team members correctly identify risks and develop action plans that will reduce the chance of untoward outcomes. A review of a sample of risk rating forms indicated that although the risk process had undergone significant improvements, all risks still were not accurately being identified. For example, • Individual #130 was rated as medium risk for cardiac disease. Her current diagnosis included hypertension, hypercholesterolemia, congestive heart failure, tricuspid regurgitation, and mild aortic stenosis. She should have been rated as high risk. Similarly, she had dysphagia and a history of stealing food. She was on a pureed diet with thickened liquids. The team rated her as medium risk for choking and aspiration. • Individual #271 was rated as low risk for fractures, though he had at least six falls over the previous year. The team considered him low risk because he had not had any fractures. His trend of falls placed him at risk for fractures.	

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		• Individual #379 was rated as medium risk for choking. He had a diagnosis of dysphagia and a history of eating too fast and overfilling his spoon. He was also rated as medium risk for cardiac disease. He had been diagnosed with hypertension and hyperlipidemia, which should have placed him at high risk for cardiac disease. He had a diagnosis of diabetes, but was only considered a medium risk for diabetes. With a current diagnosis, he was at risk for complications resulting from his diabetes and should have been carefully monitored for any resulting negative outcomes. The state policy required that all relevant assessments were submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The facility had begun to track submission of assessments by discipline and attendance at IDT meetings (see section H1). These databases will be useful when the facility begins consistently collecting and analyzing data. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health and behavioral indicators (e.g., changes in medication, results from lab work, engagement levels, mobility, peer-to-peer aggression). • Ensure that assessments are updated and submitted prior to annual ISP meetings and all relevant disciplines attend meetings and participate in discussions regarding risks. • Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. • Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. • Ensure that data collected regarding incidents and injuries are frequently analyzed for indication that supports may not be adequate for safeguarding individuals. The facility had taken many positive steps towards ensuring that an adequate risk assessment process was implemented. The monitoring team looks forward to seeing	

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		continued progress in identifying risk and developing strategies for monitoring and minimizing those risks.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	As noted throughout this report, it was still not evident that all risks were appropriately identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. Health risk ratings will need to be consistently revised when significant changes in individuals' health status and needs occurred. A sample of records was reviewed to determine if changes in circumstance should have resulted in an assessment of current services and support, risk ratings, and/or plan revisions. It appeared that teams were not always meeting immediately following a critical incident to determine if updated assessments were needed. Additionally, it was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. For example, • Individual #134 was at medium risk for falls. He reportedly became increasingly unsteady prior to a fall resulting in a serious injury. His supervision was increased temporarily due to his unsteadiness, but decreased again the day before this fall without an updated assessment by the therapist. • The ISP for Individual #379 indicated that the OT/PT recommended an extensive vision assessment due to his risk for falls. There was no documentation that the assessment was completed or if completed that recommendations were incorporated into his risk action plan. • Individual #38 was diagnosed with pneumonia on 8/7/12. There was no indication that the team met to review his risk levels or revise his HMPs following his illness. The latest revision of his risk assessment was dated 6/14/12. The facility self- assessment indicated the process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance with I2. The facility was not yet in compliance with this provision item.	Noncompliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner, if indicated by the risk status. A majority of the ISPs that were reviewed included general strategies to address identified risks, but again, not all risks were identified as a risk for each individual. The policy required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the IDT in response to risk categories identified by the team. As noted in section F, a comprehensive monthly review process was not yet in place to	Noncompliance

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	interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	ensure that plans were being implemented and monitored as needed. According to data provided to the monitoring team, plans were in place to address all risks for those individuals designated as high risk or medium risk in specific areas. The facility reported that individuals would be assessed and action plans developed using the IRRF and IHCPs as annual ISP meetings were held. IDTs had begun using the new forms as of August 2012, but were still awaiting additional training. As noted throughout this report, it was not evident that risks were being appropriately identified and action plans developed to support all risks. Risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an HMP in place or instructions were too general (follow diet plan, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. For example, • Individual #50 was rated as high or medium risk for choking, constipation, cardiac disease, weight, falls, fractures, and behavioral health. His risk action plan did not include any measurable outcomes. For example, he had one action step to address his risk for weight gain. It stated that he would receive an 1800 calorie diet. There was no ideal weight range given or directions for monitoring his weight. Without clinical indicators, the team could not measure the efficacy of his plan. • Individual #130 was at medium risk for cardiac disease. Her risk action plan stated "follow HMP" for cardiac risk. Her HMP stated that her blood pressure would remain under 140/90. It did not state how often her blood pressure would be checked or who would be responsible for monitoring it. It was not evident that consistent monitoring of those risk indicators was occurring. ISPAs were used to document initial discussion when a change in status was identified. There was not always documentation of follow-up when recommendations were made by the IDT. QDDPs were not completing a review of all supports and services. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. Furthermore, data gathered on distribution of ISPs indicated that not all ISPs were routinely filed in individual notebooks within 30 days of development. Therefore, DSPs did not have access to current risk action plans. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility self-assessment indicated that the facility was not in compliance with this provision. The monitoring team agreed with that assessment.	

Recommendations:

1. Ensure assessments are completed prior to annual IDT meetings and results are available for team members to review (I1).
2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).
3. Ensure attendance or at least input by all relevant team members in the risk process (I1).
4. All health issues should be addressed in ISPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support (I1, I2, I3).
5. Ensure IDTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).
6. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).
7. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor risks (I1 and I2).

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, notes per nursing, psychiatry notes associated with the incident, documentation of any IDT meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Ten examples of desensitization plans (five for dental and five for medical) o Any auditing/monitoring data and/or reports addressing the pretreatment sedation medication o A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols o Individuals prescribed psychotropic/psychiatric medication, and for each individual: name of individual; name of prescribing psychiatrist; residence/home; psychiatric diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact (the dates the individual was seen in the psychiatric clinic for the past six months and the purpose of this contact, for example: comprehensive psychiatric assessment, quarterly medication review, or emergency psychiatric assessment); date of the last annual BSP review; date of the last annual ISP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use o A list of individuals diagnosed with tardive dyskinesia, including the name of the physician who is monitoring this condition, and the date and result of the most recent monitoring scale utilized o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o Documentation of inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examinations for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations o A separate list of individuals being prescribed each of the following: antiepileptic medication being

	used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; Trazodone; beta blockers being used as a psychotropic medication; Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a Reiss screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who have had a Reiss screen completed in the previous 12 months o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: Information Sheet; Consent Section for psychotropic medication; ISP, and ISP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning the psychiatrists' attendance at the IDT, ISP, ISPA, and BSP meetings o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o A list of all psychiatrists including board status; with indication who has been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and inservice training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addressed polypharmacy o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy

	o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 newly prescribed psychotropic medications, Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; Positive Behavior Support Plan (PBSP); HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who has had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Ten comprehensive psychiatric evaluations per Appendix B performed in the previous six months o Documentation of psychiatry attendance at ISP, ISPA, BSP, or IDT meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months Documents Requested Onsite: o Section J presentation book o All data presented, doctor's orders, and Dr. Draksharam's documentation for psychiatry clinics, regarding Individual #37, Individual #388, and Individual #241 o All data presented, doctor's orders, and Dr. Bazzell's documentation for psychiatry clinics, regarding Individual #349, and Individual #151 o These following documents for all of these individuals: Individual #37, Individual #388, Individual #241, Individual #349, Individual #151, Individual #298, Individual #10, Individual #278, Individual #9, Individual #200, Individual #116, and Individual #109 • Identifying data sheet (most current Face Sheet) • Social History (most current) • Annual Medical Summary and Physical Exam • Active Medical Problem List (Current Diagnoses Sheet for psychiatry and medical) • Current list of all medications (MAR) • Lab section (for the last six months) • EKGs for the past year • Psychiatry section (for the last six months) • Suicide Risk Assessment (for the last six months) • Neurology section (for the past year) • Comprehensive Quarterly Nursing Assessment (for the last six months) • Comprehensive Annual Nursing Assessment (most current) • Nurse's note for psychiatry clinic • Psychology Evaluation • Psychologist's note for psychiatry clinic • MOSES/DISCUS results (for the last six months) • Reiss Screen

	• Pharmacy section (for the last six months) • Consent section for psychoactive medication and Human Rights approval • Consent section for pretreatment sedation • Pretreatment sedation assessment (for the last six months) • Integrated progress notes (for the last six months) • ISP signature sheet, and ISP addendums/reviews/annual (for the last six months) • QDDP note for psychiatry clinic • Behavior Support Plan • Safety Plan/Crises Plan • Administration of chemical restraint consult (for the last six months) • SOTP Treatment Plan (most current) • Desensitization Plan <u>Observations Conducted</u>: o Psychiatry clinics conducted by Dr. Draksharam o Psychiatry clinics conducted by Dr. Bazzell o Medical Provider meeting o Polypharmacy Committee meeting o Pharmacy and Therapeutics Committee meeting o Medication Review Committee meeting <u>Interviews and Meetings Held</u>: o Victoria Carpenter, D.O., lead psychiatrist o Jennifer Quisenberry, psychiatry assistant and back-up section head o William Earl Bazzell, M.D., facility psychiatrist o Roy Guevara, R.N., facility psychiatry nurse o Constance M. Whorton, R.N., facility psychiatry nurse o Rob Weiss, Psy.D., chief psychologist o Don Conoly, R.Ph., pharmacy director o Philip Rolland, Pharm. D., MHA, clinical pharmacy director o Scott Lindsey, FNP, lead for Integrated Clinical Services (section G)
	Facility Self-Assessment: SGSSLC submitted documentation regarding section J for the self-assessment dated 11/19/12. The psychiatry department further developed what was presented last time by including an extensive list of the results of the self-assessment. Further, they were numbered and each result had a corresponding item of the activities engaged in to conduct the self-assessment. In that regard, the psychiatry department made progress in attempting to identify activities and outcomes for each provision item. During the onsite review, the monitoring team and the psychiatry department spoke at length about the importance of detailed results of facility wide data incorporated in the self-assessment.

	The self-assessment, however, frequently focused on the results of a small sample of the statewide self-monitoring tools. As noted in conversations with the psychiatry department, there were many problems with these tools, therefore, the data collected failed to capture the relevant information required for an accurate self-assessment. The facility had not covered relevant items for all of section J as recommended by the monitoring team, but instead predominantly followed a previously designed invalid tool. The monitoring team informed the psychiatry department of the need to develop monitoring elements that matched the content of what is in the monitoring team's report. This task should be accomplished easily by establishing an outline of everything that the monitoring team comments upon in each provision item. The facility described the activities engaged in to conduct the review of a particular provision item, the results and findings from these activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The psychiatric assistant who was designated the back-up section head, provided the majority of the update for section J to the monitoring team because the lead psychiatrist was new to the department. The psychiatry department seemingly put a lot of time into completing the document. The facility self-assessment indicated what activities the facility engaged in to conduct the review. There was some improvement in the process because the activities the facility engaged in were beginning to reflect what the monitoring team outlined for the particular provision. Some of the self-ratings were informative and resembled the monitoring team's review such as J6. • For example, in J6 (each SSLC shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B), the facility summarized that only 25% of individuals in psychiatric clinic had a comprehensive assessment completed in the Appendix B format. • This provided a clear picture to the facility of the reason this section did not meet substantial compliance. It would be beneficial to additionally cite the actual number of assessments similarly outlined in the report provided by the monitoring team (e.g., given that 182 individuals were deemed to require psychiatric services, comprehensive psychiatric assessments were due for 135 individuals), since the majority of individuals at SGSSLC reportedly required psychiatric services. The conclusion was based on the results of the facility tracking the completion of the Appendix B assessments. • The facility should consider revision of the tool to conduct the auditing of the content of the evaluations in line with a peer review process to determine if the quality of the documentation met generally accepted standard of care practices. Additionally, the facility should choose a representative sample per clinician monthly because the audits for this visit only consisted of "two individuals per clinician" being reviewed monthly. Overall, the self-assessment did not provide enough detail to the psychiatry department and, thus, limited the awareness concerning the status of section J. For example in J13, the department did not provide the actual number of individuals that did not receive a quarterly psychiatric assessment and only noted that there were needed improvements in quality and timeliness. The monitoring tool called for auditing only

	two individuals per clinician monthly, but in September 2012, no audits were even completed. The monitoring team had difficulty determining what the facility accomplished in this vital section regarding the mandatory services of the psychiatrist in concert with the IDT. The facility failed to report the data in an adequate manner to portray the level of completion of duties. The facility should receive credit when individuals were reviewed in a timely fashion and this should be quoted with the exact number of evaluations conducted, as such, along with the time period since the last reporting period. The action steps included in the self-assessment packet were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns and recommendations of the monitoring team. Some of the actions were relevant towards achieving substantial compliance, but the facility will progress in a timely method if a set of actions, such as those described in this monitoring report, are set out in their entirety to capture what the facility has implemented pertinent to the items in the Settlement Agreement. The start date, projected completion date, and the completion status were determined by the facility. Some items with a start date six months ago have not been actually initiated as highlighted in the completion status section, "not started," with an example of this provided in the creation of the corrective action plans to address issues identified through the audit sample for J2 (no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board certified or board eligible psychiatrist). The self-assessment document should look at the same types of activities, actions, documents, and so forth that the monitoring team looks at, and should be modified following a review of each subsequent monitoring report. For example, in J12, the self-assessment indicated an action step of "continue current QDRR audit, which captures a wide sample of completed MOSES and DISCUS." This would be evidenced by a review of completed QDRRs with the pharmacist being the responsible party. The requirement for this provision is actually more detailed. The review should include timeliness of the assessment tools, nursing training regarding administration of the assessment tools, physician review and completion of the assessment tool, physician documentation of the use of the clinical information derived from the assessment tools such as identification of Tardive Dyskinesia, ADR reporting, and response to the side effects discovered. There should be a specified percentage of total cases reviewed with subsequent corrective action as necessary. J12 was an additional section with a start date actually greater than six months ago, specifically 5/25/12, for the creation of corrective action plans, but had not been initiated as highlighted in the completion status section as "not started." In the comments/status section of each item of the provision, there was a summary of the results of the self-assessment and the self-rating. The psychiatry department self-rated as being in substantial compliance for only one provision item (J1). The monitoring team agreed with the self-rating provided by the facility and rated substantial compliance for just the first provision in section J. The monitoring team's review was based on observation, staff interview, and document review. In discussions with the psychiatry department (i.e., lead psychiatrist, facility psychiatrists, psychiatry assistant, and psychiatric nursing staff), and the director of psychology, the need for improved integration was noted. Most provision items in this

	section rely on collaboration with other disciplines. The facility would benefit from the eventual development of a self-monitoring tool that mirrors the content of the monitoring team's review for each provision item of section J as outlined in the monitoring report, that is, topics that the monitoring team commented upon, suggestions, and recommendations made within the narrative and/or at the end of the section. Even though more work is needed, the monitoring team wants to acknowledge the efforts of the psychiatry department, particularly Ms. Jennifer Quisenberry, for continuing to proceed in the right direction. The lead psychiatrist and the psychiatric assistant can design an improved self-assessment to lead to a better set of action plans.
	Summary of Monitor's Assessment: SGSSLC provided psychiatric services by qualified physicians by virtue of their board eligibility/certification status, therefore, were found to be in substantial compliance with the first provision item. The facility, however, continued to experience difficulty with the retention of psychiatrists. As such, the primary goal must be to recruit and retain psychiatrists, such that the psychiatric program can be expanded to provide continuity of clinical services and integrated care with other disciplines. The facility had access to a psychiatrist in the community setting who had subspecialty training in child and adolescent psychiatry. This physician provided care to the youth as requested by the facility. Fortunately, in the intervening period since the previous report, the facility secured the services of a lead psychiatrist. With the previous vacancy, the maintenance of any integration beyond what could be accomplished in psychiatry clinic was delegated to the two psychiatric nurses and the psychiatric assistant. These staff provided pertinent information to the physicians regarding knowledge about the individual's past and current symptoms in order for the psychiatrist to accurately complete the evaluation (i.e., comprehensive psychiatric evaluation and the QPMRs) that guided the IDT treatment plan. There was some integration between psychiatry, primary care, and psychology achieved by discussion of case reviews in various committee meetings (i.e., polypharmacy and medication review committee). Additionally, the psychiatric clinic included representatives from multiple disciplines. This was beneficial, given that psychiatrists were not generally available to attend ISP meetings. The facility will have to be creative with regard to the use of psychiatry resources in order to achieve integration because most provision items in this section rely on collaboration with other disciplines. There were an inadequate number of psychiatric assessments completed and this affected the quality of the diagnostics and justification for treatment with medication. This task was likely hindered by a lack of consistent and insufficient number of psychiatric resources. Thus, there was an overreliance on psychotropic medications, a paucity of non-pharmacologic interventions, and use of multi-agent chemical restraints. The facility must determine the percentage of incomplete evaluations as part of the self-assessment. The different departments must communicate with one another to facilitate timeliness of the

	evaluations, applicable assessments dependent of interpretation of the presenting symptoms, and intervention to take place by the IDT. Effort must be made with respect to the development of individualized treatments or strategies and/or desensitization protocols for those administered pretreatment sedation. The Quality Assurance Report for August 2012 noted that the development of desensitization plans/treatment strategies was an area in need of improvement due to data that less than 30% of individuals who received pretreatment sedation (since March 2012) had any type of treatment in place to address this item. The psychiatry department's data collection regarding the Reiss screen illustrated that 65% of the newly admitted individuals received a Reiss screen and, of these, only 47% were completed within 30 days of the admission date. The information provided to the monitoring team was helpful and beneficial to understand the facility progress and problem areas for this section that should help guide the status of the self-assessment for this section and the corrective action plan. Psychiatry did not routinely attend meetings regarding behavioral support planning for individuals assigned to their own caseload, and was not consistently involved in the development of the plans. There were areas where psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, and collaboration regarding case formulation). SGSSLC informed the monitoring team of the intent to conduct a polypharmacy committee meeting, at least monthly, to review those individuals receiving polypharmacy, but this did not occur as planned. The polypharmacy committee inappropriately summarized the psychotropic aggregate data because even medications solely utilized for the management of a seizure disorder were included in the psychoactive count. Information about individuals not enrolled in psychiatry clinic was included in the psychotropic polypharmacy facility-level review and this skewed the data. The facility was required to develop and implement a system to monitor, detect, report, and respond to side effects of psychotropic medication using standard assessment tools, such as the MOSES and DISCUS, at least quarterly and more often when necessary based on the individual's current status. There was lack of timely administration of the standard assessment tools and inadequate utilization in clinical decision-making. The monitoring team recommended that the psychiatric department work with the nursing department to address this provision (i.e., obtaining and applying pertinent medical history discovered about exposure to medications that cause TD, reporting of ADRs during clinic process if discovered). Psychiatry must utilize this information to make this process clinically applicable for the health and safety of the individual. In most cases, the psychiatrist displayed competency in verbalizing the rationale for the prescription of medication, for the biological reason(s) that an individual could be experiencing difficulties, and for how a specific medication could address said difficulties. This information, however, must be spelled out in the psychiatric documentation.

	The facility continued to struggle in the area of informed consent. Psychology department was responsible for documentation regarding the risks, benefits, side effects, and alternatives to treatment with a particular medication. The psychiatrists were receptive to being responsible for this medical duty. There was some exchange of information to coordinate care between the psychiatrist and the community neurologist. The IDT, inclusive of the psychiatrist, however, must routinely dialogue with the neurologist, as clinically indicated, to coordinate the use of medications when they were to treat both seizures and a mental health disorder. The primary care physician must accessible during the time of the selection of medication regimen between the neurologist and psychiatrist to provide pertinent input and continuity of care particularly in regards to the treatment of the seizure disorder. The recently hired lead psychiatrist had professional expertise in neuropsychiatry and planned to develop a formal neuropsychiatric clinic for the individuals who have a seizure and mental health disorder.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications The psychiatrists who provided services at SGSSLC were either board eligible or board certified in general psychiatry by the American Board of Psychiatry and Neurology. The facility recently hired Victoria Carpenter, D.O., as the lead psychiatrist. The facility also had access to a child and adolescent psychiatrist in the community to provide care for youth, particularly under the age of 14 and/or prescribed polypharmacy with complex psychiatric conditions. As such, the professionals were qualified. Experience The psychiatrists who were employed by SGSSLC had experience treating individuals with developmental disabilities. Dr. Bazzell had prior experience caring for individuals with developmental disabilities due to services provided to MHMR programs in the state of Texas. His start date at SGSSLC was 12/1/09. Similarly, Dr. Carpenter provided care for individuals with developmental disabilities in the MHMR programs in the state of Texas. Monitoring Team's Compliance Rating Based on the qualifications of the two psychiatrists, this item was rated as being in substantial compliance. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication	Number of Individuals Evaluated At SGSSLC, 184 of the 232 individuals (79%) received psychopharmacologic intervention at the time of this onsite review. Since last visit, an additional 19 individuals were prescribed psychotropic medication. The psychiatry department tracked reasons for the increase of individuals requiring psychiatric intervention (i.e., new admissions to the facility) to account for the increased percentage of those receiving psychopharmacologic treatment.	Noncompliance

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	without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	There were a limited number of evaluations completed in Appendix B format (discussed in J6) due primarily to the lack of psychiatric staffing (addressed in J5). <u>Evaluation and Diagnosis Procedures</u> Upon observation of several psychiatry clinics during the monitoring review, it was apparent that the team members attending the visit were interested in the treatment of the individual. Although there was much effort placed into the improvement of the clinic process regarding psychiatric documentation, the monitoring team had difficulty determining the current diagnoses due to systematic discrepancy in psychiatric diagnoses across different disciplines' evaluations (e.g., physician's annual medical review, ISP, PBSP). It was recognized that many of the challenges to providing collaborative care in the facility system wide were out of the psychiatrists' control. During this review, the psychiatrist and the IDT began to entertain genetic contributants that possibly had an impact on the mental status presentation of the individual, when arriving at a psychiatric diagnosis and for selection of a psychopharmacologic regimen. This was illustrated during the psychiatric clinic observed for Individual #349. Dr. Bazzell nicely outlined that Individual #349 had phenotypic characteristics of Fragile X Syndrome, such as an elongated face and speech difficulties and, therefore, ordered genetic testing to rule out Fragile X Syndrome. The QPMR indicated that Individual #349 was prescribed a polypharmacy regimen, but there was only one psychotropic (e.g., Risperdal Consta IM every two weeks for mood disorder) listed in the psychiatric quarterly dated 12/3/12. It is important for the facility to obtain a genetic work-up when clinically indicated to rule out medical contributants presenting with psychiatric symptomatology. Individuals with Fragile X Syndrome may have developmental delays, anxiety, autism, impulsiveness, attention problems, seizures, depression, and difficulty sleeping. The identification of the syndrome may aid in the establishment of an appropriate diagnosis and treatment plan. The IDT provided thorough documentation for the quarterly psychiatric evaluation, however, the team continued to focus particularly on aggression instead of both psychiatric symptomatology associated with the identified psychiatric disorder and other behaviors. The BPRS was obtained, but rarely discussed in the clinic setting until inquiry by the monitoring team about all data available to the psychiatrist. The psychologists were receptive to feedback. The psychiatry team had not guided the psychologists in identifying specific data to be collected in order to establish if the medication regimen was efficacious. The monitoring team encouraged this type of collaboration and deemed it necessary for psychology and psychiatry to routinely work together to ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner.	

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		Clinical Justification Discussions with the facility staff revealed an awareness of the difference in quality regarding clinical documentation. The facility was in the process of implementing the newly designed QPMR. A review of a sample of 20 records revealed varying content in their completeness. The facility approved the new Quarterly Psychiatric Medication Review (QPMR) on 10/8/12. The QPMR was a comprehensive document that captured the necessary elements of a psychiatric assessment. This form included input from the QDDP, nurse, associate psychologist, and even had a section about the coordination of care between neurology and psychiatry. The facility should arrange for an electronic QPMR as a template to utilize during clinic with a computer and projector. The documentation addressed pertinent medical information and included categories, such as a current medication list (non-psychotropic and psychotropic), laboratory data, ECG results, case formulation, and Axis I, II, and III that enhanced attention to pertinent categories to address clinical care. In several of the psychiatry clinics, the psychiatrist stated that the diagnosis in the record was probably not accurate and not in line with the DSM-IV-TR and, therefore, requested further review of the case to determine the appropriate diagnosis. If diagnostics are not appropriately addressed in a clinically justifiable manner, the other provisions, such as polypharmacy regimens will not be successfully addressed. In summary, there was concern expressed by the psychiatry department about their attempts towards ensuring that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist. Tracking Diagnoses and Updates The psychiatry department implemented a database under the direction of Jennifer Quisenberry, psychiatry assistant, to track diagnoses and capture diagnostic updates. For example, a numbered spreadsheet of individuals prescribed psychotropic medication listing Axis I, II, and III diagnoses were provided with dates of clinical contact. The psychiatry department should set up a database to automatically calculate the next date of the quarterly visit. The facility had not provided self-assessment data to calculate how many individuals of the 184 received a timely evaluation and the determination of the level of deficiency for this section. The self-assessment noted the total number of individuals receiving medication, but generally summarized that, due to the lack of completed documentation, this provision was not in substantial compliance. The information collected by the psychiatry department should guide diagnostic updates facility wide in an organized fashion.	

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		Challenges The facility made progress with regard to working on the system of addressing the content of the quarterly psychiatric assessments at the expense of the limited number of completed Appendix B evaluations. The monitoring team explained to the facility that if a quarterly examination was due, the psychiatrist could complete an Appendix B instead, being a more comprehensive document that served the same purpose. As they had managed to complete some psychiatric assessments, it was necessary for this information to be utilized facility wide, specifically highlighting the justification of diagnosis, collaborative case formulations, treatment planning with regard to psychotropic medication, and the identification of non-pharmacological interventions. Monitoring Team's Compliance Rating The monitoring team would like to acknowledge the hard work of the facility staff with regard to the design and recent implementation of the quarterly psychiatric assessments in the new format. Based on the early stage of development for the psychiatrists to appropriately document delivery of care (i.e., QPMR), and the lack of completion of evaluations to ensure that no individual received psychotropic medication without having been diagnosed in a clinically justifiable manner, this item was rated as being in noncompliance.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Treatment Program/Psychiatric Diagnosis Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. The monitoring team was informed of several individuals prescribed psychoactive medication who did not have an Axis I diagnosis and were not enrolled in psychiatry clinic, such as Individual #278. Additionally, as outlined in J15, the QDDR dated 7/25/12 incorrectly listed Individual #278 as receiving a psychotropic medication with an appropriate indication, but this individual did not have an Axis I diagnosis. This reflected case examples of individuals receiving psychotropic medications in the absence of a psychiatric diagnosis and poorly integrated care because Individual #278 had a seizure disorder and was prescribed an AED medication regimen. Per the review of 20 records, all but one individual had diagnoses noted in the record. Individuals prescribed psychotropic medication must have a current PBSP. The details of the content of the PBSPs are discussed in section K. The self-assessment provided by the psychiatry department for this item summarized that there were a high rate of PBSPs outdated and assessments had not documented discussion or the need for alternative treatment programs. There was no indication that psychotropic medications were being used as punishment, for the convenience of staff, or as a substitute for a treatment program. It will be important for	Noncompliance

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		ongoing collaboration to occur between psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. This activity should advance due to the development of the new QPMR (discussed in J2). In this process, the IDT will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of psychopharmacologic medications. It was notable that in the prior PBSP documents, information included the psychotropic regimen, medication side effects, and medication changes that were not consistently developed in collaboration with the prescribing physician. This practice was revised because information regarding the individual's psychopharmacological regimen will not be in the PBSP, but outlined in the treatment plan developed by the psychiatrist with the IDT. Additionally, consent for psychotropic medication had not yet been turned over to the prescribing physician's responsibility from the psychology department, therefore, insufficient and inaccurate content of the medication information was then forwarded to the HRC for approval. A team approach to psychiatry clinic was observed during the review; psychology representation and other staff disciplines were present in the psychiatric clinic. There were efforts made to justify diagnostics and pharmacological interventions. An expansion to include the consistent review of non-pharmacological interventions, either occurring or proposed for a specific individual, was necessary. The IDT was encouraged to review the content of the PBSP with the psychiatrist via psychiatry clinic on a periodic basis. This collaboration in the psychiatry clinic setting would also allow for discussion and subsequent documentation with regard to non-pharmacological interventions in both the IDT plans, such as the BSP and the psychiatric treatment plan. <u>Emergency use of psychotropic medications</u> The monitoring team was provided a numbered spreadsheet of individuals requiring utilization of chemical restraints in the last six months. There were 142 incidents with dates of administration ranging from 4/1/12 to 9/30/12. Last review, the facility provided data for 12/1/11-6/1/12 with 129 incidents recorded. Several individuals received more than one administration of this restrictive measure (i.e., Individual #9, Individual #24, Individual #34, and Individual #346). The chemical restraint upon each administration was frequently a combination of medications administered via intramuscular injection (Thorazine and Ativan, or Haldol and Ativan). The psychiatry staff informed the monitoring team that they had discontinued the use of pro re nata (PRN) administration of medication for every individual at SGSSLC, however, during the last review, the psychiatrist stated Individual #9 occasionally refused the oral form of the psychotropic medication prescribed, therefore, was immediately administered	

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		the medication in an intramuscular form. Last review, the monitoring team inquired about the intention of this measure (i.e., was this a stat emergency medication or was this a PRN order). The monitoring team explained to the IDT that an individual had the right to refuse treatment unless other review measures were in place (i.e., court ordered treatment, necessity of emergency use of medication). The IDT was receptive to this feedback from the monitoring team. Upon review of data provided this reporting period, Individual #9 received 22 chemical restraints for self-injurious behavior. • The treating psychiatrist elected to discontinue the standing order for Individual #9 (i.e., no longer routinely received an intramuscular agent upon refusal of medication). This reflected progress in the consent process (J14). Caution was advised to carefully monitor target symptoms and staffing practice to prohibit the emergency administration of psychotropic agents becoming an aid for staff convenience when someone experienced some difficulties. This was particularly important due to the complex side effects associated with a psychopharmacological regimen alone as well as when in combination with other medications prescribed for medical purposes and/or pretreatment sedation. Documents were provided for the last 10 individuals who required chemical restraint. Some, however, did not have any psychiatric or IDT documentation in the record pertaining to the incident (i.e., Individual #26, Individual #346) • The Post-Chemical Restraint Clinical Review form dated 9/14/12 was blank for Individual #26 regarding input from the pharmacist, psychiatrist, and for nurse monitoring. Staff should attend to these requirements as outlined. • The absence of the psychiatrist in the review of this type of restrictive intervention with the IDT resulted in a missed opportunity to foster strategies to reduce the use of emergency medication. Upon interview of several departments regarding the topic of chemical restraints, there was progress in the systematic review and sharing of knowledge about this critical information in a multidisciplinary manner as witnessed in the Medication Review Committee meeting. This was encouraging because in a prior review, the monitoring team was informed that the lead psychiatrist was not even a member of the committee that reviewed chemical and protective supports. <u>Monitoring Team's Compliance Rating</u> As discussed above, there was a need for improvement of psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. The new structure of the QPMR (discussed in J2) was an aid to the IDT for the selection of sound interventions for each individual. The goal of the team should	

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		include the reduction of psychopharmacologic medications, if not clinically indicated. The different departments (i.e., nursing, pharmacy, medical, psychology, psychiatry) must communicate with one another for addressing utilization of restrictive measures (i.e., emergency chemical restraints) to allow for appropriate assessment and intervention to take place by the IDT. Therefore, this item was rated as being in noncompliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Policy and Procedure</u> The Pretreatment Sedation Notification and Referral for Assessment Process Procedure dated 2/22/11 was revised 7/26/12. This included Attachments, such as the Pretreatment Sedation Notification Form" and the Dental/Medical Desensitization Assessment Form. The forms outlined sections to allow for the multidisciplinary team input to address this provision that called for coordination of services, including as appropriate, psychiatric, pharmacy, and medical services. For example, the associate psychologist was to address if the individual received systematic desensitization. The pharmacy representative was to document if there was any contraindication to using the medication. If the individual was enrolled in psychiatry clinic, the psychiatrist was to review if there was any contraindication to using the proposed pretreatment medication. <u>Extent of Pretreatment Sedation</u> The facility reported a total of 40 instances (4/1/12-9/30/12) of pretreatment sedation for medical purposes. There was no administration of pretreatment sedation for dental procedures during this time period. A total of 21 individuals received pretreatment sedation with one individual receiving as many as six administrations (Individual #38). In order to evaluate the extent of pretreatment sedation utilized at SGSSLC, the calculation provided by the facility was one comprehensive list of individuals who received pretreatment sedation medication or TIVA for medical or dental procedures. The list was comprised of the individual's name, whether the individual received psychiatric services, designation of whether it was medical or dental pretreatment sedation, date the pretreatment sedation was administered, name, dosage, and route of the medication, date of ISP, and date of the desensitization plan. This was an excellent outline of the essential components and highlighted that of the 21 individuals, 90% received psychotropic medication in addition to the pretreatment sedation. The summary should also include if the psychiatrist participated in the review and completed the psychiatrist's section of the Pretreatment Sedation Notification Form. This would aid the facility in determining the percentage of individuals who received coordination with the psychiatry department for this provision item and the results should be included in the self-assessment summary. Individuals participating in psychiatry clinic who were prescribed psychotropic medication, such as Individual #116, did not receive pretreatment sedation in coordination with the IDT. This individual's record was one of the examples provided by the facility of someone	Noncompliance

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		receiving psychotropic medication who required pretreatment sedation. • Individual #116 received Thorazine 100 mg po for a medical pretreatment sedation. The team should have thoroughly established a risk-benefit analysis for this individual who had crystal deposits in her eye, but received Thorazine that further increased the medical risk. Individual #116 should have received vigilant monitoring as recommended by the ophthalmologist. Further, the documentation submitted for this individual did not reflect an interdisciplinary process as it was noted "record did not contain psychiatry notes pertaining to this sedation." • A psychiatric pretreatment sedation review was of the highest priority for this individual who received a polypharmacy regimen of seven psychotropic medications every day according to the polypharmacy committee data. • Record review by the monitoring team revealed conflicting information from the polypharmacy committee because Individual #116 had a seizure disorder and two of the AED medications had a neurological indication. It was important for the facility to adequately track indications and appropriate information for administration of psychotropic medications. The monitoring team recommended that for any data submitted, that each page included at least the name of the individual and preferably the date. There was no name or date included in the packet for numerous individuals. This was not in reference to the face page of the document requested which included this information, but to the actual content of the packet submitted. In the event that some data were separated from the individual's record, it would be beneficial to know to where the data belonged. It would be helpful for the facility to review and provide the pretreatment sedation notification form completed by the team because this may have been where the psychiatrist documented involvement as opposed to the progress notes due to the revision of the procedure. The ISP dated 8/14/12 had a section outlined for pretreatment sedation and noted that, for the most part, Individual #116 was compliant for dental assessments. Additionally, it was documented that there was not a need for supports in relation to medical sedations either. The psychiatrist did not attend the ISP for Individual #116, but the nursing staff assigned to the psychiatry department was present. Separate reviews for Individual #201 revealed similar findings, such as a page being included in the submitted packet with the notation "record did not contain psychiatry notes pertaining to this sedation," but failed to provide the pretreatment sedation notification form that may have been where the psychiatrist documented the involvement as opposed to the progress notes due to the revision of the procedure. The monitoring team requested	

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		10 examples of documentation of psychiatry consultation regarding pretreatment sedation for dental or medical clinic, but only six examples of documentation were ultimately obtainable/usable. Individuals who were prescribed psychotropic medication were subjected to potential drug-drug interactions when they received similar medications for medical or dental procedures, therefore, a concerted effort between disciplines was required. Because medications utilized for pretreatment sedation could result in unwanted challenging behaviors, sedation that could be mistaken by psychiatrists as symptoms of a psychiatric condition, or mistaken as side effects from the regular medication regimen, the communication regarding the utilization of pretreatment sedation must take place. <u>Interdisciplinary Coordination</u> Interdisciplinary coordination should review if adjustments to the individual's existing regimen could be made in an effort to reduce the duplication of medications administered. For example, individuals scheduled for pretreatment sedation may require a reduction in dosage of scheduled benzodiazepines in order to avoid over-medication. To date, interdisciplinary coordination was minimal, as evidenced in the lack of documentation. Different departments were attempting to address this, sometimes in isolation, thus, there was a disjointed approach to this section. Interviews with psychology and psychiatry revealed an expectation that there should soon be improvement in collaboration with the dental department since the recent hiring of a dental director who was also assisted by a full-time dental hygienist. The facility should understand that the goal of this provision item is development of treatments or strategies to minimize or eliminate the need for pretreatment sedation. That is, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects. <u>Monitoring After Pretreatment Sedation</u> Ten examples were provided to the monitoring team regarding nursing follow-up and monitoring after administration of pretreatment sedation. The case examples revealed that 20% of this sample were not assessed and monitored adequately (e.g., Individual #178, Individual #294). The physician's orders dated 9/4/12 did not list anything about how the vitals were to be monitored for the medication monitoring for Individual #178. Monitoring was warranted after pretreatment sedation when being administered sedating medications, particularly when utilized in combination with other medications prescribed	

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		for medical and/or psychiatric conditions (that may have a negative clinical outcome). The clinical pharmacist would also be instrumental in providing the medication side effects and potential interactions of pretreatment sedation agents with concurrently prescribed medication. Desensitization Protocols and Other Strategies A list of all individuals with medical/dental desensitization plans and date of implementation was requested. There were a total of five desensitization plans listed. Three of these plans were implemented since the last review, all in the month of October 2012 for Individual #130, Individual #236, and Individual #344. One of these desensitization plans was implemented for an individual who received pretreatment sedation for a medical procedure (e.g., Individual #344). The QA Report for August 2012 noted that the development of desensitization plans/treatment strategies was an area in need of improvement. The QA report summarized that less than 30% of individuals who received pretreatment sedation (since March 2012) had any type of treatment in place. A Systematic Desensitization PIT was formed to address this issue. Furthermore, requests were being sent monthly to the psychologists of those individuals who received pretreatment sedation and did not have treatment in place, for an assessment be completed and strategies implemented. Further effort must be made with respect to the interdisciplinary review of pretreatment sedation and development of desensitization programs. They must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual. Monitoring Team's Compliance Rating This item remained in noncompliance with recommendations to capture the data of the multidisciplinary team inclusive of the psychiatrist's participation, when applicable, in this process. The summary should include if the psychiatrist completed the psychiatrist's section of the Pretreatment Sedation Notification Form for the review of this section. This would aid the facility in determining the percentage of individuals who received coordination with the psychiatrist and a multidisciplinary review for each individual administered a pretreatment medication. The results of the data should be cited in the self-assessment summary.	

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J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	<u>Psychiatry Staffing</u> Approximately 82% of the census received psychopharmacological intervention at SGSSLC as of 12/3/12, which was a three percent increase since last review. Of these, four individuals were younger than 18 years of age. • The facility tracked reasons for the increase in utilization of psychotropic medications and informed the monitoring team there were 19 new admissions since last review, with four being readmissions. The medication regimen for 95% of these individuals consisted of psychotropic medications upon admission to SGSSLC. The psychiatry department secured a full time lead psychiatrist who was designated as the department head since the last review. The lead psychiatrist suitably outlined a summary of the requirements of the chief position with notation that the assignment called for at least a one-half time position that would allow for sufficient hours to initiate, evaluate, and coordinate integration across disciplines regarding the requirements of the psychiatry section of the Settlement Agreement instead of the one-quarter allotted time frame. There were two full time board eligible general psychiatrists employed at SGSSLC, inclusive of the chief psychiatrist. The only locum tenens psychiatrist was contracted through 12/31/12. Last review, there were two FTE psychiatric physicians providing services at the facility. Dr. Bazzell informed the monitoring team that he was responsible for psychiatric call coverage via telephone consultation after hours. Otherwise, each of these psychiatrists worked five days per week, a minimum of eight hours each day. As a result of the above, the psychiatry department consistently indicated that a minimum of three FTE psychiatrists would be required in order to allow the psychiatrist to provide care for the individuals at SGGSLC. It was noted that each psychiatrist attended IDT, ISPA, and other various meetings as needed. The three FTE psychiatrists would include enough time for the completion of the Appendix B comprehensive assessments, quarterly reviews, attendance at meetings (e.g., polypharmacy committee, IDT meetings, behavior therapy committee, physician's meetings, behavior support planning), other clinical activity, such as collaboration with primary care, nursing, neurology inclusive of neuropsychiatric clinics, other medical consultants, pharmacy, psychology, provision of emergency psychiatric consultation, and more frequent monitoring for individuals whose medication dosages or regimen had recently been adjusted. Two registered nurses (RNs) were designated to work full-time in the psychiatry clinic to assist each psychiatrist with making rounds and gathering pertinent information for quarterly reviews and Appendix B comprehensive evaluations. However, one of these	Noncompliance

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		nursing staff had an injury that resulted in not being able to assist the psychiatry department for the time period of October 2012 to December of 2012. The two nurses joined the psychiatric team in October 2011. During the interview with the monitoring team, they expressed a common goal inclusive of a commitment to improvement of clinical documentation, continuity of care with other disciplines, and facilitation of integration of services for the individuals served at SGSSLC. <u>Administrative Support</u> The psychiatric assistant, Jennifer Quisenberry, was the back-up section lead. Ms. Quisenberry was comfortable in numerous areas regarding this position and was receptive to working with the psychiatrists, medical staff, and other disciplines. She was a valuable asset to the psychiatry department and provided information for section J during this visit because the new lead psychiatrist was recently hired and started in her formal position only on 11/28/12. Ms. Quisenberry previously worked in the psychology department and gained knowledge of completing various assessments, such as the Reiss, desensitization programs, and other vital information related to the psychiatry clinic. She collaborated with other departments to address section J and diligently gathered requested documentation. Other duties included administrative support to the psychiatrists for scheduling evaluations, obtaining records and contact information, and collection of pertinent data. During the monitoring visit, she was informative, understood the elements of the Settlement Agreement for provision J, such as the necessity of integration of clinical services between disciplines, and was instrumental to the psychiatry team. <u>Determination of Required FTEs</u> Overall, it appeared that SGSSLC had done an adequate job in assessing the amount of psychiatric FTEs required. The number of hours for the conduct of the psychiatry clinic were developed to take into account not only clinical responsibility, but also documentation of delivered care such as quarterly reviews, neuropsychiatric consultations, and Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility, participation in pharmacy and therapeutics committee, medication review committee, and in polypharmacy meetings). <u>Monitoring Team's Compliance Rating</u> The facility provided a self-rating of noncompliance in the self-assessment for this item because of the inadequate number of FTE psychiatrists. SGSSLC had not yet demonstrated a consistent ability to employ or contract with a sufficient number of psychiatrists to provide the services required. The facility should begin to make progress because of the appointment of the lead psychiatrist to organize and guide the psychiatry team in the delivery of psychiatric services.	

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J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Appendix B Evaluations Completed</u> SGSSLC reported that only 26% of the evaluations, as described in Appendix B, had been completed. Given that 182 individuals were deemed to require psychiatric services, comprehensive psychiatric assessments were due for 135 individuals, therefore, this provision remained in noncompliance. • The data indicated an average of three assessments were completed per month. • At this rate, it would take approximately four years to complete all of them, without any new admissions to the facility. <u>Review of Completed Evaluations</u> Upon review of the requested 10 Appendix B style evaluations performed in the previous six months, there was noticeable improvement in the content and format in how the documents were completed. A sample of the Appendix B style evaluations performed in the previous six months was submitted and reviewed for the following individuals: Individual #220, Individual #267, Individual #292, Individual #140, Individual #354, Individual #363, Individual #35, Individual #247, Individual #207, and Individual #108. The title of the Appendix B evaluation was noted as an "initial," that would indicate the first examination when, actually, psychiatric consults other than a comprehensive assessment had already been completed. Other titles were "annual" that would indicate the evaluation would be completed every year. The monitoring team encouraged the facility to identify the document as referenced in the Settlement Agreement for the clarification of the purpose of the evaluation. The psychiatrist sufficiently completed the assessments with some exceeding the intent of the section. The format was followed for the Appendix B outline and reflected an improvement in documentation since the last review. The psychiatrist outlined, in the medical history, all of the current medications, inclusive of dosage. Medical data, such as status of labs (e.g., chemistry profile, lipids, thyroid function test, urine drug screen) were included in the comprehensive evaluation, however, orthostatic vital signs must be included in the report for individuals receiving psychotropic medication. The psychiatrist must guide the team in concert with the PCP for what is required of the team in monitoring of vitals and parameters (e.g., hold the medication for pulse less than…), especially for individuals prescribed an antihypertensive agent in combination with psychotropic medications that can result in orthostatic hypotension, change in pulse, etc. The Appendix B evaluation for Individual #247 dated 9/11/12 consisted of 26 pages that exceeded the requirements of J6. The purpose of the comprehensive assessment per the Settlement Agreement is to capture the pertinent features of the individual to result in a	Noncompliance

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		treatment regimen applicable to the individual's symptom presentation and diagnosis. While it was positive to see that the psychiatrist developed a comprehensive document inclusive of a thorough case formulation, the facility should consider a streamline of the lengthiness of these evaluations that already required a lot of time to complete. For example, a large section of the medical history and physical dated 2/8/12 was entered in the 9th category of the Appendix B outline for Individual #247 when this category was intended to reflect only pertinent findings of the physical examination. <u>Monitoring Team's Compliance Rating</u> The facility self-rated noncompliance due to Appendix B evaluations not being completed for the majority of individuals receiving psychiatric services. Given the remaining number of comprehensive psychiatric assessments this provision remained in noncompliance.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at SGSSLC, only for those who did not have a current psychiatric assessment. The Reiss screen should also be administered to those individuals with a change in psychiatric and/or behavioral status. The monitoring team received a list of 17 individuals who were new facility admissions for the previous six months, with three being recently community placed, but readmitted, and whether a Reiss screen was completed. Sixty-five percent of the newly admitted individuals received a Reiss screen. In order to calculate this percentage, in regards to the timeliness of the completion of the Reiss screens, the list provided via the document request outlined the name of the individual, date of admission, and date of the completed Reiss. The information provided to the monitoring team was helpful and beneficial for understanding the facility progress and problem areas for this section. This should help guide the preparation of the self-assessment. The Reiss screens were completed within 30 days of the admission date for 47% of the new admissions. The psychiatry department documented that numerous attempts were made to obtain updated information about the status of the Reiss screens from the psychology department (i.e., 7/11/12, 8/3/12). The two departments must share this vital information, have similar data, and work together to address this section. Psychiatry should be aware of the findings of the Reiss screen in order to determine if the individual warranted psychiatric intervention.	Noncompliance

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		Reiss Screen for Each Individual (excluding those with current psychiatric assessment) The psychiatry and psychology departments were in the initial stages of addressing this provision and were struggling with the intent for the administration of the screen. For example, if there was a current psychiatric assessment, the psychology department may have also obtained a Reiss Screen for those residing at the facility. The reason for completing such screens was not clear to the monitoring team because it was not attributed to a change in the individual's status. This process placed undue burden on the psychology department. The psychiatry department's data collection regarding the Reiss screen included, but was not limited to, a numbered, alphabetized list with the date of the screen, whether the individual was referred to psychiatry due to a high result of the screen or change in status, and a category for comments to indicate if the individual was reviewed in the psychiatry clinic. This provision requires that all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner. This topic was summarized in J6. Reiss Screen for Change in Status There must be a rescreen if there is a change in status. If the screen so indicated, a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) was to then be attained in a clinically justifiable manner. The psychiatry department received a referral regarding Individual #125 because of a change in status, was administered a Reiss screen 9/24/12, and evaluated per psychiatry on the same date. There was not a completion of a comprehensive psychiatric assessment, but Individual #125 was enrolled in the psychiatry clinic roster to receive treatment. This type of collaboration was essential to the health and well being of individuals requiring psychiatric intervention. There was no specific process, however, for determining when a change in status should result in a Reiss screen being implemented. The facility should become familiar with other state centers in regards to addressing time frames. Consideration should be given to reasonable timelines (e.g., within one week for initiation of consultation following a positive screen and no later than 30 days to complete the comprehensive psychiatric evaluation). Referral for Psychiatric Evaluation Following Reiss Screen Psychiatric review occurred for 95% of the new admissions to the facility, therefore, the Reiss screen was not the reason to produce a referral for the psychiatric evaluation this	

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		review period. Monitoring Team's Compliance Rating Given the challenges with the lack of consistency of obtaining Reiss screens and, if so, sometimes not in a timely fashion, the deficiency in the integration of services identified in this section, and those with a psychiatric diagnosis or prescribed psychotropic medication not receiving a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis was warranted) in a clinically justifiable manner, this provision remained in noncompliance.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Policy and Procedure The SGSSLC facility-specific policy and procedure dated 10/8/12 regarding psychiatric services addressed how the combined assessment and case formulation occurred (i.e., via clinical assessments, and obtaining interdisciplinary information of essential elements in a biopsychosocial and spiritual order that affects the individual's condition, functional abilities, and quality of life). Interdisciplinary Collaborative Efforts The monitoring team observed several separate psychiatric clinics held with different IDTs. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (i.e., psychiatry, psychology, nursing, QDDP, direct care professional, and the individual). Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 30 minute) observations/interactions with the individuals, as well as the review of information provided during the clinic. The psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress, and reviewed the plan to make any medication changes, if any were needed. An IDT process (i.e., ISPA) essentially occurred within the psychiatry clinic, with representatives from various disciplines participating. This was good to see and showed continued progress. Combined Assessment and Case Formulation The facility self-assessment noted that this section was not in substantial compliance because integration between psychology and psychiatry needed additional documentation to illustrate combined case formulation and case assessment. The components of the case formulation were outlined in Appendix B. The case formulation should consist of "sequential tasks, undertaken to channel distinct disciplinary assessments into the creation of an integrated treatment plan." These steps should include identification of factors (i.e., biological, psychological, social, spiritual) with design of habilitation and interdisciplinary	Noncompliance

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		treatment processes to meet the individual's needs. Psychology and psychiatry need to formulate diagnoses and plans for the treatment of all individuals as a team. The psychiatrists were in the beginning phase of focusing on the particular psychiatric diagnosis and the reason the medication was prescribed. There was participation in the discussion and collaboration, but the team did not consistently ask for, or provide, data of the essential target symptoms that were deemed necessary for monitoring of the current psychiatric diagnosis. One area of progress was the availability of the results of the BPRS, but unfortunately the scale was not always reviewed in the psychiatric clinics. The use of objective instruments (i.e., rating scales and screens) that are normed for this particular population may be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. Further, depending on what document was reviewed, there were varied diagnoses assigned between disciplines. These differences impacted the overall review of efficacy of pharmacological treatment and also altered the determination of specific behavioral and other interventions specific to the individual's needs. As previously mentioned, individuals did not receive timely psychiatric follow-up further resulting in lack of integrated pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. For example, for Individual #298: • He was not evaluated by psychiatry for 10 months. The last quarterly evaluation occurred 3/8/12 and there were numerous assigned Axis I Diagnoses (i.e., Intermittent Explosive Disorder, PDD, Asperger's Syndrome, and ADHD). • The active problem list provided to the monitoring team was dated 8/11/11 and Individual #298 was cited with other diagnostics in addition to those in the psychiatric evaluation (i.e., Bipolar Disorder). • 8/29/12 physician's annual medical summary and physical examination noted similar diagnostics to the most recent psychiatric evaluation except for PDD. • The indication for Chlorpromazine varied dependent on what document was reviewed (i.e., thought disorder, but the MAR cited it was for aggression/mood control.) • The Initial Psychiatric Evaluation dated 8/31/10 incorporated a copy and paste of three entire categories from the DSM-IV-TR in the report (i.e., Conduct Disorder, Asperger's Disorder, and Antisocial Personality Disorder) that instead should have only included relevant information specific to Individual #298. • The monitoring team requested the psychological evaluation and was informed that there was no psychological evaluation in the record for Individual #298.	

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		In summary, the team had not integrated pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. It was difficult for psychology and psychiatry to establish a working relationship because of the staff turnover and lack of completion of evaluations. For example, turnover resulted in different psychiatrists being responsible for the psychiatric care of an individual, and as a result, diagnostics and treatment regimens changed. When this occurs without the integration and support of the IDT, and without a history of combined case formulation, psychiatry and psychology will not be (and were not) aligned. As a result, for example, they did not identify similar content, and there were differences in the identification of the target symptoms (psychiatry) and target behaviors (psychology) that would be applicable to the assigned diagnosis. <u>Monitoring Team's Compliance Rating</u> Due to the absence of completed combined assessment and case formulation, this provision remained in noncompliance.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for	<u>Psychiatry Participation in PBSP</u> Psychiatrists did not routinely attend meetings regarding behavioral support planning for individuals assigned to their caseloads and were not consistently involved in the development of the plans. This arrangement negatively affected the decision making process in regards to recommendations of other less intrusive measures, diagnostics, and indications for utilization of psychotropic medication. The monitoring team was provided information that psychiatry failed to attend any of the Behavior Support Plan Committee meetings from April 2012 to September 2012. Members of the psychiatry team (i.e., RN or psychiatrist) attended 23 of the ISP meetings and two ISPAs. This further illustrated decline in IDT participation because previously there were 37 entries documenting the psychiatrists' involvement in annual reviews, initial, and updated IDT meetings. During the time period of having a full team lead psychiatrist, there were 53 entries listed. Therefore, this item should improve next review with the chief psychiatrist facilitating collaboration with other disciplines. The facility self-assessment noted that this item was not in substantial compliance because integration documentation of the IDT and psychiatrist's discussion to determine supportive interventions to minimize the need for psychotropic medication was not consistent. It would be best for the facility to calculate the numbers of cases that met the requirement for J9 for the facility to understand what work was unfinished. The psychiatry assistant nicely illustrated this by listing the names of the individuals enrolled in psychiatry clinic and the date of the PBSP and ISP, however, she did not put yes or no to track if the psychiatrist attended or participated. This would be an easy way to calculate the percentage of involvement before a proposed PBSP has been implemented and also the participation of	Noncompliance

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	psychotropic medication to the degree possible.	psychiatry in the IDT meetings. The psychiatrists stated a willingness to become more involved, but indicated that a lack of clinical time and requirements of their attendance at other meetings would likely make this impossible. Furthermore, there had been change of staff in the psychiatry department resulting in lack of knowledge about the individual's history and response to psychiatric treatment. To meet the requirements of this provision item, there needs to be evidence that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item and that the required elements are included in the document. The Appendix B evaluations documented non-pharmacological intervention recommendations (i.e., psychotherapy, behavioral cognitive therapy, and milieu therapy), with some evaluations completed shortly after the admission to the facility, before the proposed PBSP had been completed. This information should be utilized for the proposed PBSP, such as outlined in the example in J10 for Individual #140. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed in the psychiatry clinic, during the already regularly scheduled clinics, with additional reviews as clinically indicated. The monitoring team noted that the behaviors being monitored and tracked, and the behaviors that were the focus of positive behavioral supports, were not necessarily chosen due to the identified psychiatric diagnosis. The monitoring team provided summary in the last report encouraging the psychiatrist to meet with the IDT <u>before</u> a proposed PBSP is implemented for individuals receiving psychiatric care. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> During the psychiatric clinics observed, the psychiatric staff and IDT engaged in some discussion of non-pharmacological interventions provided to the individuals (e.g., participation in anger management classes). It was positive to witness the IDT's efforts in utilizing non-pharmacologic treatment. The ISP documentation for the member's signature lines that were typed made it easier to determine the various disciplines that were in attendance.	

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		Monitoring Team's Compliance Rating Psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. The monitoring team was provided information that psychiatry did not attend any of the Behavior Support Plan Committee meetings where the proposed PBSPs were reviewed from April 2012 to September 2012. There was also further decline in IDT participation during this reporting period. Therefore, this provision item was rated as being in noncompliance.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Policy and Procedure The SGSSLC facility-specific policy, Psychiatric Services dated 10/8/12, included the exact language from the Settlement Agreement and was to be accomplished via input from various team members including the psychiatrist, nurse, and associate psychologist. Quality of Risk-Benefit Analysis The facility was in transition to turn over the responsibility from the psychology department to the prescribing physician of establishing a risk-benefit analysis. Comments regarding the risk-benefit analysis for treatment with psychotropic medications and restrictive programming were previously included in the PBSPs. These were, however, authored exclusively by psychology staff without medical review and, therefore, did not satisfy the requirements of this provision item or meet generally accepted professional standards of care. Per staff interview and record review, there had been minimal change in practice with regard to this provision since the previous review. The current review of the records of 20 individuals who received various psychotropic medications were beginning to reflect documentation by the psychiatric physician of an individualized specific risk-benefit analysis with regard to treatment with medication as required by this item. This was particularly evident in the Appendix B evaluations that were completed this reporting period for those newly admitted to the facility. The psychiatry department must also utilize the findings in the quarterly drug regimen reviews (QDRRs) to enhance clinical care of the individual. The QDRRs were available as an ongoing tool developed for systematic review for those individuals receiving medication, such as psychotropics (section N). Again, the risk-benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician. The success of this process, however, will require a collaborative approach from the individual's treatment team, inclusive of the psychiatrist, primary care physician, psychologist, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring are provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the	Noncompliance

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		risk-benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item. The psychology department and the psychiatry department were receptive to changing this process (which was reviewed during the previous visit and summarized the last monitoring report). There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications. The monitoring team stressed the importance of the psychiatrist and the IDT reviewing the content of this provision and, further, that is was not adequate to have medications outlined with generic statements along with the restrictive programming plan. In the consent process, the explanation of the medication, its class, dosage, and purpose should be specific for the individual. The facility had gathered important clinical information, but did not summarize the case material in an applicable manner for the care of the individual once the findings were discovered. The monitoring team acknowledged progress in the psychiatrists beginning to address risk-benefit analysis, particularly in the Appendix B evaluations. For example, Individual #140 had an initial psychiatric evaluation completed shortly after her admission to the facility. The document was thorough and included an extensive psychiatric and medical history. There was a designated section for the treatment plan and recommendations where the psychotropic medications, adverse reactions, and drug interactions were cited, and even a section to indicate whether or not the QDDR was reviewed. This was excellent progress to address this item. The psychiatrist also outlined the non-pharmacological intervention for this individual, including psychotherapy, behavioral cognitive therapy, and milieu therapy. It was noted that the associate psychologist would formulate a behavioral support plan after completing a functional assessment and Reiss screen. The one element that was missing was a statement actually outlining a risk-benefit analysis specific to Individual #140, an individual with multiple medical problems (i.e., morbid obesity, sleep apnea, hypothyroidism, hyperlipidemia) to determine if the possible harmful effects of the psychotropic medications that Individual #140 received (i.e., Divalproex, Zyprexa, Seroquel, and Hydroxyzine), which had the potential to cause, contribute and exacerbate further side effects (i.e., weight gain, dyslipidemia, etc.) were clearly indicated for the evidence-based approach in line with the psychiatric condition or if simplification (i.e., one dose reduction) of at least one medication was necessary.	

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		Observation of Psychiatric Clinic The development of the risk-benefit analysis could be undertaken during psychiatry clinic. The analysis must be specific to the individual's care and not reflect a cut and paste content of specific side effects for a medication. For example, if an individual had problems with being overweight, diabetic, and hypertensive, the psychiatrist would have to factor in the medical conditions before considering the administration of psychotropic agents that may further worsen the individual's health status. This documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. During the psychiatric clinics observed by the monitoring team, the psychiatrist discussed some of the laboratory findings with the IDT, but did not thoroughly outline findings in the documentation in the records in the form of a risk-benefit analysis. The QPMRs listed a number of pertinent findings from various disciplines, but the psychiatrist will need to process the information and then decide risk-benefit and treatment decisions based on the results. This should be an ongoing process and not accomplished in only one clinic setting. The psychiatrists stated that this should be their role and enthusiastically participated in the psychiatric clinics observed. Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). The descriptors presented to HRC continued to be authored by the psychology department for the consent for psychotropic medication and did not meet generally accepted professional standards of care because it did not reveal sufficient documentation by the psychiatric physician of an individualized specific risk-benefit analysis, yet even so, the plans were approved. The next reporting period, the committee should have received consents written by the staff in the psychiatry department with appropriate risk-benefit analysis with information relevant to the assigned diagnosis and specific to the individual's health status. Monitoring Team's Compliance Rating There was a need for improved assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be effective, or potentially more dangerous, than the medication. The input of the psychiatrist and various disciplines must occur with supporting documentation in order for the facility	

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		to meet the requirements of this provision item.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	<u>Facility-Level Review System</u> SGSSLC informed the monitoring team of the intent to conduct a polypharmacy committee meeting, at least monthly, to review those individuals receiving polypharmacy. The facility self-assessment summarized that this section was not in compliance because monthly reviews pertaining to individuals on polypharmacy did not occur consistently. Since the last review, the polypharmacy committee provided documentation dated 8/29/12 about the issues discussed in the meeting. The polypharmacy committee inappropriately summarized the psychotropic aggregate data because medications solely utilized for the management of a seizure disorder were included in the psychoactive count. Information about individuals not enrolled in psychiatry clinic was included in the psychotropic polypharmacy facility-level review and this skewed the data. An example was provided in J15 regarding Individual #278 who did not receive psychoactive medication and was not enrolled in psychiatry clinic, but the data from the polypharmacy committee incorporated the medication count inappropriately. The monitoring team attended the polypharmacy meeting. The meeting was well attended by numerous staff (i.e., pharmacy director, clinical pharmacy director, lead psychiatrist, psychiatric assistant, interim medical director, psychology representative). The monitoring team was provided a list regarding which individuals were prescribed a polypharmacy regimen, including the number of the psychotropic medications. The facility-level data included the overall information of how many individuals were prescribed psychotropics, and of these individuals, who received intraclass and/or interclass polypharmacy. Data also outlined the names of individuals who received three medications, four medications, five medications, and so on. The polypharmacy committee composed of key staff charged with the development of a facility-level review system, did not understand how to set-up the pertinent data/information collection reflective of the facility wide review, with some members antagonist towards the feedback and guidance from the monitoring team. In fact, during the week of the visit, the pharmacy staff in the P&T committee presented the same skewed polypharmacy data the next day without any warning to the attendees that the data were gathered erroneously. The definition of psychoactive medication, established for this section, was not understood by the staff in the pharmacy department because there was confusion about including medications that may affect the brain and behavior even when the indication was not for a psychotropic purpose.	Noncompliance

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		The monitoring team explained that numerous medications prescribed by the medical staff, such as beta blockers and calcium channel blockers for hypertension and AEDs for seizure disorder, may affect the individual's psychiatric symptomatology and behavioral presentation but if the medication was not given for the purpose of a psychiatric indication, then the medication should not be counted in the polypharmacy count regarding psychoactive medications. The list of medications affecting the brain and behavior prescribed for other purposes are endless, thus, the reason why there is an importance for the IDT to be monitoring all of the medications together. The facility self-assessment entry for this provision noted that there were 56 individuals prescribed polypharmacy in May 2012, but an increase to 167 in August 2012 when the new procedure to report polypharmacy was implemented. This information was not reviewed in June 2012 or July 2012 according to the facility self-assessment. It was imperative for the facility to have detailed data of an applicable facility-level review system to address the prescription of intraclass and interclass polypharmacy. A member of the polypharmacy committee reported to the monitoring team that it was best to over report hence the inclusion of all of the additional medications, but this is not the purpose of this section. Of course, some individuals may require a polypharmacy regimen, but this should not be the norm. As was discussed during the onsite review, in some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must, however, justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. This forum should be the place for a lively discussion regarding reviews of the justification for polypharmacy derived during psychiatry clinic. This element was missing because the record and the details of the cases reviewed were not present (e.g., medical record not reviewed in the committee) or utilized until prompted by the monitoring team to obtain. The pharmacy department should be knowledgeable about the information that is collected in the psychiatry department and vise versa in regards to this provision. Review of Polypharmacy Data For onsite reviews by the monitoring team, it would be helpful for the facility polypharmacy review to always take place at the beginning of the week so that the monitoring team can provide feedback throughout the remainder of the week. The facility arranged for the polypharmacy committee to be held the first day of the visit and this was beneficial for understanding the facility-level approach regarding ensuring that the use of such medications was clinically justified, and that medications that were not clinically justified were eliminated. Additionally, a Pharmacy and Therapeutics Committee (P&T) meeting was held the next day.	

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		The polypharmacy data from the pharmacy director to the psychiatry assistant dated 9/20/12 were provided to the monitoring team and indicated that a total of 106 individuals received polypharmacy, but did not list the number of individuals prescribed psychotropic medication to determine the percentage. The facility must calculate this type of information as part of the self-assessment to understand the relevance of the items collected. Regarding polypharmacy, two individuals received seven psychotropic medications (Individual #46, Individual #116), nine received six medications, 17 received five, 35 received four, and 41 received three. The names of the individuals were provided. The monitoring team encouraged the committee to address the reasons for the change in rates of utilization (e.g., accurate definition of polypharmacy, new admissions prescribed polypharmacy) to provide a reliable facility level review system. The clinical indicators outlined for the review of identified individuals were not reflective of an evidence-based practice for evaluating efficacy of the selected medication regimen. Thus, the team could not accurately detect if the medications were effective for the identified psychiatric illness because data were not designed to capture this information. The facility should consider a psychiatric peer review system regarding polypharmacy in order to provide feedback to one another and to address this serious aspect of delivery of psychiatric services, particularly in SGSSLC's environment of staff changes in psychiatry. <u>Review of Polypharmacy Justifications</u> The intention of the facility-level review was to ensure that the uses of psychotropic medications were clinically justified, and that medications that were not clinically justified were eliminated. Numerous individuals had agitation and/or aggression listed as the indication for the medication without identification of a specific diagnosis for which the medication was prescribed. This pervasive practice pattern of unjustified polypharmacy regimens will continue without establishing an evidence-based practice by the psychiatric team. The polypharmacy committee must be aware of all medications that the individual was prescribed in order to further determine the next plan of action. Individuals with a psychiatric illness, particularly those also with a neurological condition, such as a seizure disorder, must be analyzed in view of their overall medical condition in regards to potential drug-drug interactions. Additionally, case review and integration of data for individuals prescribed pretreatment sedation and polypharmacy were imperative in order to avoid further drug-drug interactions for those already prescribed numerous medications. Thus, the importance of ongoing monitoring for side effects, reporting of adverse drug reactions, and review of finding of the QDRRs remained very important.	

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		Monitoring Team's Compliance Rating The facility must have an effective process for monitoring and ensuring the review of polypharmacy. The psychiatrists were responsible for outlining the justification of such regimen. Given the ongoing challenges noted above with regard to the currently established system level of review of polypharmacy, ineffectively addressing that medications that were not clinically justified were eliminated, this provision was rated in noncompliance.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	Policy and Procedure The requirements of this section required at least the quarterly administration of a standard assessment tool and more often when necessary based on the individual's current status. • The updated facility policy and procedure regarding psychiatric services dated 10/8/12 outlined that the MOSES must be completed at least every six months. The administration of the DISCUS was to occur at least every three months. Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) The MOSES and/or DISCUS were not being completed in a timely manner. Additionally, the log of when the tool was administered was not maintained. The nursing and psychiatry department did not work in partnership to guarantee the tools for monitoring side effects of psychotropic medication were obtained, not only according to schedule, but also when there was a change in status. There were no administrations of such scales utilized during the psychiatry clinics observed for individuals who definitively had a change in status as acknowledged by staff present in the clinic, such as with Individual #338 or for those with scales not completed in a timely manner. In the psychiatry clinic conducted by Dr. Draksharam, Individual #338 exhibited numerous oral buccal abnormal motor movements and had difficulty remaining seated due to constant restlessness. Upon inquiry by the monitoring team about the etiology of such presentation, the nursing staff stated that the DISCUS and MOSES scores, each obtained 11/29/12, were both zero. This was the textbook example of when the staff should obtain a follow-up side effect screening scale for this individual with obvious abnormal motor movements. Dr. Draksharam documented in the mental status examination dated 12/5/12 for Individual #388 that the "monitor said that he may have side effects." This was not appropriate to cite such information because the monitoring team is not part of the facility staff. The nurse actually stated the findings were new upon inquiry by the monitoring team. The staff required further training to know how to assess an individual with a change in presentation such as Individual #388. The monitoring team's function, of course, is not to diagnose or conclude if individuals were experiencing side effects, but does have the responsibility to inquire about the applicability	Noncompliance

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		of the findings of the psychiatrist and the IDT to meet the standard of care in regards to the delivery of psychiatric services. If the individual had a prior score of zero and then had presenting symptoms of numerous abnormal motor movements, the IDT was required to intervene and reassess. It was good to see that the psychiatrist noted that Individual #338 may have tardive akathisia given his medication history. Dr. Draksharam further noted that Individual #338 may have had a medication induced movement disorder, NOS, and was a candidate for a neuropsychiatric review. The completion of an adverse drug reaction form should also occur during the psychiatric clinic when an ADR was discovered. In response to the document request for a spreadsheet of individuals who had been evaluated with MOSES and DISCUS scores, the facility provided information regarding scores and completion of evaluations on 10/19/12, but the document did not highlight the time frame indicating when the data were captured (e.g., 4/1/12-9/1/12). Review of these data revealed delay in completion of the MOSES and DISCUS, with numerous individuals not administered either scale for the past six months. For example, Individual #57, Individual #55, Individual #280, and Individual #346 did not receive any scale for the past six months. The facility must calculate the percentage of individuals who received the DISCUS and the percentage of individuals who received the MOSES administration as part of the facility self-assessment and also to spark awareness of who required the administration of these side effect screening measures. It would be helpful to identify the reasons for not obtaining a follow-up with N/A and notation if the individual was discharged from the facility or no longer received psychotropic medication, if this was the case. Psychiatry must utilize this information and work together with nursing to obtain the updated information in a timely and clinically-based approach. Five individuals were prescribed Reglan (Metoclopramide). Individuals receiving Reglan must receive routine screening similar to those prescribed neuroleptic medication. These individuals did not have a diagnosis of TD. • Individual #60 received Reglan, but was not administered a DISCUS or MOSES in the past six months. • Individual #125 was one of the individuals who received Reglan, but the scales were not obtained because there was the notation N/A without any further explanation. In addition, Individual #125 was also prescribed a neuroleptic, Zyprexa, which should have resulted in the completion of these tools. <u>Training</u> For facility nursing staff, training occurred for 95% of the nursing staff hired. A total of 37 nurses completed the training. The facility should include training of ADR reporting, preferably in the same time frame with the MOSES and DISCUS education, in order for staff	

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		to associate the purpose of the monitoring/detecting with the reporting requirement. Once any side effects were detected, reporting was to occur and response taken based on the individual's status. When an individual experienced an adverse drug reaction, reporting of the finding, such as by filling out an ADR, was to occur. ADRs (e.g., unexpected, unintended, undesired, or dangerous effect that a drug may have that occurs at doses used in humans for prophylaxis) are reviewed in section N. <u>Quality of Completion of Side Effect Rating Scales</u> The names of 13 individuals were provided to the monitoring team who had the diagnosis of some type of dyskinesia due to medication, such as tardive dyskinesia, and sub-acute dyskinesia. The facility did not provide adequate history about prior neuroleptic history in the completion of the rating scales or in the records of most of the individuals reviewed this visit. It is important to document this because the knowledge about the history of exposure to prescribed medications, such as neuroleptics and metoclopramide, is an important factor when assessing the risk of TD. Although medications, such as antipsychotics and metoclopramide, may cause abnormal involuntary motor movements, the same medications may also mask the movements (i.e., lowering DISCUS scores). Medication reduction or absence of the antipsychotic or metoclopramide that occurred during a taper, due to medication noncompliance, medication error, or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as Attention-Deficit/ Hyperactivity Disorder, Bipolar Disorder, etc. Therefore, all diagnoses, inclusive of TD, must be routinely reviewed, considered, and documented. <u>Monitoring Team's Compliance Rating</u> Given the need for the demonstration of the consistent administration of the standard assessment tools and for the appropriate utilization of this information in clinical decision-making, this provision was rated as being in noncompliance. It is recommended that the psychiatry department work with the nursing department to address this provision (i.e., obtaining and applying pertinent medical history discovered about exposure to medications that cause TD).	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist,	<u>Policy and Procedure</u> SGSSLC facility-specific policy and procedure was updated on 10/8/12 and displayed a comprehensive process cohesive with the content of the Settlement Agreement. Attachments were part of the policy with one being the Quarterly Psychiatric Medication Review (QPMR) that focused on addressing the content of this section. This outline was an excellent measure to prompt the psychiatrist and the IDT to safeguard that the evaluation identified a clinically justifiable diagnosis, the expected timeline for the therapeutic effects	Noncompliance

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	shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	of the medication to occur along with target symptoms to be monitored, and other pertinent features relevant to this section. Per a review of the DADS statewide policy and procedure Psychiatry Services, effective 8/30/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision item. The facility policy and procedure entitled, Establishing and Changing Diagnosis, 9/15/11, was to improve and unify each individual's diagnosis and succinctly outlined the process of how to change a diagnosis. This was an important element for the IDT to create cohesive treatment plans. <u>Treatment Plan for the Psychotropic Medication</u> The treatment plan for the psychotropic medication would have to be designed with the IDT to establish cohesive diagnostics across disciplines. If a psychiatrist changes a diagnosis, the IDT should be aware of the reasons for the choice of the new diagnosis over the old one, and allow the IDT to change the treatment plan accordingly. A review of documentation inconsistently justified the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral/pharmacological treatment hypothesis). Other required elements (the expected timeline for the therapeutic effects of the medication to occur, the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur) were not constantly outlined. Per record reviews for 20 individuals, some of the information required to meet the requirements of this provision item were included in the psychiatric assessment, but not necessarily in a timely or reliable manner. The monitoring team was informed that Individual #116 received a polypharmacy regimen of seven psychoactive medications and that this was cause for concern and monitoring. The monitoring team reviewed the record for Individual #116 and discovered there had not been a psychiatric consultation since 6/14/12. This was unacceptable because the facility must provide psychiatric treatment identified in the treatment plan, no less often than quarterly, and especially based on the current status of the individual. The facility must recognize any potential drug-drug interactions and identify the necessary delivery of care applicable to the individual. Upon the monitoring team's inquiry about drug-drug interactions for numerous individuals examined in the psychiatry clinics, the answer provided was that the nursing staff from the psychiatry department had the interactions in their office, but it was not available or reviewed in the psychiatric clinic. On a positive note,	

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		the staff was receptive to feedback regarding the importance of recognition and knowledge about the potential side effects and drug-drug interactions and looked up the material on their smart phones during clinic. Further, it should not have been necessary for the monitoring team to be the only reason for the team to attend to this issue. Upon additional record review for Individual #116, this individual had an extensive history of medical illnesses (i.e., seizure disorder, obesity, diabetes mellitus type II, syndrome of inappropriate antidiuretic hormone, hypothyroidism, hyperlipidemia, fatty infiltration of the liver, and vitamin D deficiency). The IDT should have thoroughly reviewed this because Individual #116 was prescribed intraclass and interclass psychotropic polypharmacy and these medications could have caused, contributed to, or exacerbated the cited medical conditions. • The annual summary and physical examination dated 7/23/12 provided a detailed review of the psychiatric consultations, for example, that the last psychiatric evaluation conducted 6/14/12 noted crystals in the eye secondary to the Thorazine, but the individual continued to receive this agent at the time of the review. A prior taper of Thorazine had been ordered, but if the psychiatric examination would have occurred in a timely fashion, the medication may have already been successfully discontinued. During the onsite visit, the facility discussed the frequency of obtaining eye examinations for those individuals receiving antipsychotics, particularly Seroquel. The monitoring team encouraged the facility to perform an adequate risk-benefit analysis for those receiving antipsychotic medication, inclusive of a detailed past history of neuroleptic exposure to determine what was necessary care and to also weigh the recommendations identified for the medication monitoring as outlined by the pharmaceutical company in references such as the PDR. An informed consent process must take into consideration many variables pertinent to the individual as outlined in section J10. The details of an individual's treatment plan, such as the case formulation, arrival at diagnostics (i.e., Bipolar Disorder Type I, Rapid Cycling), and reasons that a medication may have exacerbated versus ameliorated symptoms of a psychiatric disorder (e.g., an antidepressant may worsen the condition of the Bipolar Disorder without the use of a mood-stabilizing agent) should be clearly noted, along with what symptoms to monitor and how the individual could benefit from other less restrictive interventions, such as psychotherapy. Polypharmacy utilized must be coordinated with the indication summarized for each medication and including additional information about the ineffectiveness of the prior monotherapy regime, thereby, justifying additional medication.	

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		Documentation outlining all individuals with a current psychotropic medication regimen, their diagnoses, and the frequency of their psychiatric clinic visits was provided, but the facility did not calculate the number and percentage of individuals who did not meet the standard of monitoring frequency by the psychiatrist and IDT. The data were collected from 4/1/12 to 10/1/12 and provided to the monitoring team. Per review of this documentation, there were numerous instances in which the last psychiatric clinic for an individual exceeded three months, indicating that several individuals were not seen in clinic on at least a quarterly basis. This was the case for Individual #153 who received a large number of psychoactive medications (six) as outlined in the polypharmacy committee data. Based on the psychiatry database, Individual #153 failed to receive necessary care due to his last consult being held on 5/18/12. It should be noted that while multiple individuals were out of compliance with regards to receiving quarterly clinic reviews, there were also some individuals that were, in fact, seen in clinic more frequently than quarterly. For example, Individual #269 had clinical contacts listed for 4/2/12, 5/18/12, and 6/22/12 inclusive of an initial, interim, and quarterly assessment. The monitoring team encouraged the facility to model and calculate the necessary type of information in order to self-assess each section of this provision and to identify areas in need of further attention. For this section the facility outlined that the assessment audit tool showed 6% of the documentation revealed a justifiable diagnosis, expected timelines for therapeutic effects, and determined behavior characteristics monitored in order to evaluate treatment efficacy. <u>Psychiatry Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the ISP process (addressed in J9). The facility recently employed another full time psychiatrist and had relied on contracted psychiatric providers. The schedules and turn over of psychiatric staff did not allow their attendance at the majority of ISP meetings. In an effort to utilize staff resources most effectively, the facility could consider incorporating some components of the IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT in psychiatry clinic may allow for improvements in overall team cohesion, information sharing, collaborative case conceptualization, and management. This provision required that every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, must ensure that the treatment plan for the psychotropic medication addressed the cited requirements of this provision based on the individual's current status and/or changing needs, no less often than quarterly.	

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		Psychiatry Clinic The monitoring team attended several clinics. The psychiatry clinics were conducted in the home of the individual, in a cramped, hot, and inadequate work area for the IDT to review records, discuss data, write progress notes, and interview the individual. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this provision. Recommendations include accomplishing this goal together with the IDT by holding lengthier clinics (e.g., 45-60 minute for the individual consult), accessing equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time would be necessary to set up the shell of the document. The availability of a projector or screen and typing the information during the clinic process was recommended. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The records for the individuals scheduled for evaluation on Monday, 12/3/12, the first day of the monitoring visit were not available to the psychiatrist and IDT. The monitoring team was told that the records were in another building because a different clinic was held on Friday, 11/30/12, and the records were not returned to the appropriate place in the individual's home setting. This was of major concern because the staff did not have the record to review the details of the case history and staff were not able to chart findings in the record, when clinical necessary, that were mandatory duties of the multidisciplinary team. The psychiatry clinics were delayed for various reasons during the week of the visit. One of the reasons was the necessity to move the meeting to a better-ventilated and spacious room (i.e., kitchen area). Upon one occasion, the psychiatrist and the nursing staff assigned to the psychiatry department were not present for the first 20 minutes of the scheduled clinic while the IDT waited patiently. During another clinic, the records of those scheduled for clinic had to be located and hindered the beginning of the clinic. The clinics were not run efficiently and this may have been the result of only having one nurse to coordinate all of the psychiatry clinics. On a positive note, once the clinics began, the teams did not rush, spending an appropriate amount of time (i.e., 30 minutes) with the individual and discussing the individual's treatment. Pertinent medical information, weights, laboratory data, and MOSES and DISCUS results were reviewed. In all instances, the individual was present for the clinic. All treatment team disciplines were represented during each clinic. The data presented to the psychiatrist predominantly focused on behavioral presentation (e.g., agitation, SIB, aggression towards others) and did not consistently include relevant psychiatric target symptoms of the assigned diagnostics to determine medication efficacy.	

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		The IDT focused on aggression until prompted by the monitoring team. After the first day of the review, the IDTs paid more attention to the assigned diagnostic spectrum. There were numerous individuals observed who had apparent dysmorphic features indicative of a possible genetic disorder. The psychiatrist stated that a screen for genetics had not been included as part of the medical work-up in the psychiatric clinic, but now planned to order testing as clinically indicated. The monitoring team explained that the IDT must screen for individuals who have features representative of syndromes (i.e., Down Syndrome, Fragile X Syndrome) because individuals with genetic syndromes also suffer with medical illnesses that require intervention and preventative medical attention. <u>Medication Management and Changes</u> The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication. Dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response, the physician can determine the benefit, or lack thereof, of each medication adjustment. The problem remained that when the psychiatrist inquired if the individual was doing "better," the psychiatrist and the IDT had not outlined what would constitute if an individual had improved (i.e., reduction of psychotic symptoms for someone who had Schizophrenia). The topics outlined in this section of the Settlement Agreement, where a significant portion of overall psychiatric treatment is reviewed (i.e., treatment plan, psychiatric clinic) had been thoroughly discussed with the facility by the monitoring team regarding what would be required to meet substantial compliance. Unfortunately, the facility had not addressed this section accordingly and only appeared to address the identified components of this section by day two of the visit, due to the feedback by the monitoring team. <u>Monitoring Team's Compliance Rating</u> Per a review of the facility self-assessment, this provision was rated in noncompliance. A review of a sample of 20 records revealed varying quality in documentation for the psychiatric reviews, with most of the deficiencies noted in the identification of a clinically justifiable diagnosis to ensure that the treatment plan for the medication was consistent with generally accepted professional standards of care. Therefore, the facility remained in noncompliance for this item.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case	<u>Policy and Procedure</u> Per DADS policy and procedure Psychiatry Services dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures."	Noncompliance

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	of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The facility-specific policy Psychiatric Services dated 10/8/12 outlined the psychiatrist's role in obtaining consent for psychotropic medications. Per this policy, SGSSLC "must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications (or other restrictive procedures)." At SGSSLC, the lead psychiatrist informed the monitoring team that psychology obtained consents for psychotropic medications. The psychology staff had been responsible for the coordination of consent for psychotropic medication due to difficulty with the hiring and retention of psychiatry staff (J5). Both the medical and psychology departments were receptive to the prescribing physician being responsible for obtaining consent for the psychotropic medication. The monitoring team is in agreement with this plan. The monitoring team recommended that the prescribing practitioner for the medication regimen was the party responsible for establishing the content of the consent to ensure the designated representative for the individual (i.e., LAR/Guardian) understood the risk versus benefit analysis. The facility should handle this medical consent consistent with other medical policy and procedures for obtaining consent. <u>Current Practices</u> Dr. Bazzell informed the monitoring team of his efforts to obtain some of the consents, particularly for the new prescription of a psychotropic medication, but this was not yet implemented facility wide. The general practice at the facility was that the psychologist filled in the content for the consent. The monitoring team encouraged the psychiatrists to oversee the medical content required for consent. The lead psychiatrist and the chief psychologist agreed with this recommendation. The monitoring team requested 10 examples of consent for those who were prescribed new psychotropic medications. One of these individuals (Individual #220) received recommendations to begin a new regimen, but the monitoring team was informed there was no consent in the individual's record regarding the use of psychotropic medication. Individual #108 was prescribed one psychotropic medication and other medications, such as an antiepileptic medication for seizures. The consent for the use of the psychoactive medication adequately noted the description of the expected benefit of the antidepressant medication being to target symptoms of depression. Additionally, it was good to see that standard alternative treatments were listed, inclusive of therapy and a behavior support plan to target challenging behaviors in order to provide measures such as non-pharmacological interventions. This example illustrated progress in the consent format. In regards to the side effects	

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		section, only the most common were cited. Consent should be relevant to the individual, therefore, for Individual #108, the side effects of the selective serotonin reuptake inhibitor, Lexapro, should have included the possible lowering of the seizure threshold because this individual had a seizure disorder. The highlighted prescribing information by the manufacturing company for Lexapro (Escitalopram Oxalate) included a warning and precautions summary for "Seizures: Prescribe with care in patients with a history of seizure." Additionally, this medication had a black box warning of an increased risk of suicidal thinking and behavior (suicidality) in short-term studies of major depressive disorder (MDD) that was relevant to Individual #108's diagnostic assignment, but was not included in the consent explanation. These two additional side effects summarized by the monitoring team were applicable and should have been included in the consent for Individual #108. Individual #108 signed the consent, but it was deemed Individual #108 did not have the capacity to consent for this intervention. The consent documents did not include the name or discipline of the person giving explanation of the content of the consent. There usually were several names listed, frequently not legible, and it was unclear to whom and when the information was provided. Thus, it was impossible to determine if the person who granted approval understood the risks versus the benefits of the selected medication. Further, staff must review the estimated duration of the validity of consent for the medication, consistent with established state consent guidelines and whether this should be less for specific measures (i.e., pretreatment sedation). A consent form, once completed, was presented to the Human Rights committee for review before a non-emergency medication was given. In an effort to address the inadequacies in informed consent practices, it was recommended that the facility consult with the state office, who, in turn, may want to consider a statewide policy and procedure outlining appropriate informed consent practices for the administration of psychotropic medication that comply with Texas state law and generally accepted medical practice. This should not preclude the facility from proceeding with implementation of informed consent by the physician because a psychiatrist should be competent in this task without the direction of a specific policy and procedure. <u>Monitoring Team's Compliance Rating</u> This provision remained in noncompliance due to the inadequate informed consent practices at SGSSLC.	

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J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medications are prescribed to treat both seizures and a mental health disorder." There was also a facility-specific policy and procedure Communication with Neurologist dated 4/7/11 with revisions 8/25/11 with the purpose to ensure appropriate communication between the physicians and neurologist. Facility wide updated policy and procedure Psychiatric Services dated 10/8/12 listed this section in the Integrated Care portion and outlined the necessity of the coordination between the psychiatrist and the neurologist regarding the use of medications, but did not list the IDT as a necessary participant of the process. The policy, however, highlighted that findings would be presented in the quarterly review forum that included members of the IDT. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic The monitoring team received a numbered alphabetized list of 48 individuals participating in psychiatry clinic who had a diagnosis of a seizure disorder. Last visit, there were 52 individuals who required neuropsychiatric intervention. The psychiatry department made progress sustaining a roster of individuals who would require the coordination of care by a neurologist and a psychiatrist to treat both seizures and a mental health disorder. These data would facilitate determination of the necessity of neuropsychiatric services. Adequacy of Current Neurology Resources There had been efforts to coordinate care with neurology. Psychiatry staff stated information pertaining to psychotropic medication and/or other concerns were provided to the neurologist for individuals who received psychiatric services from April 2012 through September 2012. While this collaboration was a movement in the right direction, to date, there had been no reference that a neuropsychiatric clinic was ever scheduled. However, the psychiatry staff stated that there had been telephone contact between the psychiatrist and the neurologist, but this information was not captured to date. The recently hired lead psychiatrist had professional expertise in neuropsychiatry, traumatic brain injury, and psychiatric aspects of seizure disorder. She had a goal of developing, implementing, and monitoring the efficacy of treatment delivered via a formal neuropsychiatric clinic for the individuals who had a seizure and mental health disorder. Because the components of this section have not been adequately addressed by the facility, Dr. Carpenter, will lead this particularly important section due to her expertise in this area. The facility calculated this section would require up to eight hours per week on the part of	Noncompliance

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		the psychiatrist to outline accurate case history that would be presented to the neurologist in the neuropsychiatric clinic. The calculation of FTE for the psychiatry department was addressed in J5. Neuropsychiatric consultation requires the participation of a neurologist and a psychiatrist. The treating psychiatrists did not meet with the neurologist because individuals requiring neurological consultation were evaluated in the community setting. Neurology clinics occurred a couple of times per month. The monitoring team was informed that Dr. Chris Vanderzant, one of the community neurologists, knew many of the individuals because he had provided neurology care for them for many years. Two additional neurologists were listed as providing services to a total of two individuals. SGSSLC should consider ways of formalizing the consultation between the neurologist and the psychiatrist through the IDT process to routinely coordinate the care of these individuals. Scan calls between the IDT inclusive of the psychiatrist and primary care physician with the neurologist would be beneficial in delivery of care and review of polypharmacy. For example, everyone participating in the conference call would have a current list of all medications, the individual's medical record, neurology record, psychiatric information, etc. to make informed decisions about the necessary medication regimen and indications for the all of the medications. The monitoring team was informed that anyone receiving an AED regimen was counted in the psychotropic polypharmacy data even though the individual was not assigned a psychiatric diagnosis. This was reflected in the example regarding Individual #278. Per record review of the consent section, Individual #278 did not receive a psychotropic medication and was not enrolled in psychiatry clinic, but the data from the polypharmacy committee included Individual #278 in the count of those who received a psychoactive medication. • The ISP dated 5/2/12 noted that Individual #278 did not take psychoactive medications. He had a seizure disorder diagnosis. • The monitoring team reviewed the record of Individual #278. The documentation NA was listed for the section of neurology consults that were to be retained for 24 months or most current. • The QDRR date 7/25/12 highlighted that Individual #278 received a psychotropic medication, the indication for the medication was appropriate and the comments NA was checked in response to the question if Individual #278 experienced seizures in the past 24 months. • The indication of the AED medication regimen was for the sole purpose of the treatment of the seizure disorder and therefore should not be deemed a psychotropic medication for Individual #278.	

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		Numerous medications utilized to target medical conditions, such as calcium channel blockers, beta blockers, and numerous other agents may impact cognitive and behavioral presentation, but are not referenced as a psychotropic medication unless it was the indication for the medication. The first step would be to establish the indication for the AED class of medications related to the Individual's medical and psychiatric condition. The indications for the medications need to be discussed because an AED for seizure disorder may not be warranted for the Axis I disorder and, therefore, the indication would only be for the seizure disorder. There was a pervasive pattern noted throughout the record review and upon observation of the psychiatric clinics and team meetings that numerous individuals received an AED medication, yet the team was not able to confidently state the purpose of the medication. The recommendation to discontinue a medication, such as a benzodiazepine or an AED prescribed for an Axis I disorder may result in occurrence of increased frequency of seizure activity because these medications may also reduce seizures. Thus, the psychiatrist should obtain consultation with the neurologist through the IDT process, prior to discontinuation of an anti-epileptic agent, particularly for individuals with a seizure disorder. Similarly, the neurologist choosing an agent without the psychiatrist's involvement is not encouraged due to the potential exacerbation of the individual's psychiatric presentation. Regardless, the change in medication, whether AED from the neurologist or adjustment of psychotropic from the psychiatrist, should occur with the plan of one medication change at a time while monitoring seizures, side effects, drug-drug interactions, and mental status. <u>Monitoring Team's Compliance Rating</u> The facility remained in noncompliance with this provision item due to the facility being in the beginning stages of the neurologist and psychiatrist coordinating the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	

Recommendations:

1. The facility to provide the names of everyone who worked in the psychiatry department for the past six months, including the exact dates of their employment or contract work, and the vitae for the staff outlining board status and experience treating individuals with developmental disabilities (i.e., lead psychiatrist, every locum tenens psychiatrist, nursing staff in the psychiatry department, psychiatry assistant, and consulting community child psychiatrist). This request will be added to the next document request (J1).

2. The facility should utilize a database to track essential elements of the delivery of services by the psychiatry department, including but not limited to, information confirming current diagnostics, indications of treatment regimen, and tracking of consultation dates in order to ensure individuals were evaluated in a clinically justifiable manner (J2).

3. The facility should calculate the actual number of individuals that did not receive a quarterly psychiatric assessment. The facility should receive credit when individuals were reviewed in a timely fashion and this should be quoted with the exact number of evaluations conducted along with the time period in which the assessments were completed since the last reporting period (J2, J13).

4. Continue the data collection regarding the use of emergency psychotropic medications. Include PRN medication in the count of psychotropic medication, with the following information: the name of the medication, dosage, duration of use, indication, date consent was obtained, and by whom (J3).

5. It will be important for collaboration to occur between psychology and psychiatry to formulate a cohesive differential diagnoses and case formulation, and to jointly determine clinical indicators. In this process, the IDT will, it is hoped, generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and discuss strategies to reduce the use of emergency medications. It was also imperative that this information was documented in the individual's record in a timely manner (J3).

6. Data collected for J4 should include if the psychiatrist completed the psychiatrist's section of the "Pretreatment Sedation Notification Form." Individualize the desensitization plans for dental and medical clinic. Implement cross-discipline consultation regarding pretreatment sedation options. The clinical pharmacist can provide the potential interactions of pretreatment sedation agents with concurrently prescribed medication to the IDT (J4).

7. Develop work-load indicators to determine optimal utilization of present staffing, taking into account not only clinical responsibility, but also documentation of clinical care and required meeting time (e.g., physician's meetings, staffing, behavioral management consultation, emergency IDT meetings, discussions with nurses assigned to psychiatry, call responsibility) (J5).

8. Complete the comprehensive psychiatric evaluations following the requirements of the Settlement Agreement Appendix B. The lead psychiatrist and psychiatry assistant should establish a schedule and procedure for Appendix B evaluations to be completed. The psychiatry staff should utilize a consistent numeral system with similar categories in order to address all of the components as outlined in Appendix B (J6).

9. Administer the Reiss screen for each individual as outlined in provision J7. The facility to determine the mechanism for referral and documentation for those individuals requiring a psychiatric evaluation following a positive Reiss Screen or following a change in psychiatric or behavioral status. The facility to clarify timelines within which the Reiss screen and Appendix B evaluations will be completed (J7).

10. Ensure that the clinical indicators/diagnoses/psychopharmacology for all individuals prescribed psychotropic medication are appropriate (J2, J8, J13).
    a. If DSM-IV-TR diagnosis was met, utilize medication that has validated efficacy as supported by evidence-based practice, and that was the appropriate course of intervention in concert with behavioral intervention.
    b. Review the target symptoms and data points currently being collected for individuals prescribed psychotropic medication. Make adjustments to the data collection process (i.e., specific data points) that will assist psychiatry in making informed decisions regarding psychotropic medications. These data must be presented in a manner that is useful to the physician (i.e., graph format, with medication adjustments, identified antecedents, and specific stressors identified).
    c. For each individual, this information must be reflected in the case formulation and psychopharmacological treatment plan with illustration of collaboration with the IDT. The team integration should be measured via consistency in the records across disciplines.

11. Integrate the prescribing psychiatrist into the overall treatment program at the facility as follows (J3, J8, J9, J13):
    a. In discussions regarding treatment planning and behavioral support planning;
    b. Utilize the psychiatric treatment plan for psychotropic medications written per the psychiatrist in the overall team treatment plan;
    c. Ensure the individual's psychiatric diagnosis is consistent across disciplines;
    d. Involve psychiatrists in decisions to utilize emergency psychotropic medications;
    e. Psychiatry should be consulted regarding non- pharmacological interventions.

12. Formalization of the IDT reviews of the risk-benefit ratios for each the prescription of psychotropic medications and to be authored by psychiatry. The risk-benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician, however, the success of this process will require a collaborative approach from the individual's treatment team inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptom monitoring is provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk-benefit analysis (J10).

13. Ensure a multidisciplinary, facility level review to monitor at least monthly, the polypharmacy trends, aggregate data, prescribing practices, and justification for the psychotropic medication regimens prescribed (J11).

14. The psychiatrist should utilize the findings obtained via the polypharmacy review committee and the QDDR as it relates specifically to the review of the prescribing psychiatrist's practice pattern regarding polypharmacy. Continue efforts to improve physician documentation of the rationale for the prescription of specific medications as well as for the rationale and potential interactions when polypharmacy is implemented (J11).

15. Code Medication-Induced Movement Disorders on Axis I. Provide a numbered alphabetized list of individuals that received a DISCUS and MOSES with the dates of completion for the past two evaluations inclusive of the scores of each screen (J12). The time frame must be highlighted about when the data were captured. The facility must calculate the exact number of individuals and percentage of individuals that received the screening tools in a timely manner as part of the self-assessment.

16. Any change in diagnostics should summarize the symptoms and criteria met according to DSM-IV-TR to justify the diagnosis. The 90-day reviews of psychotropic medication must include medication treatment plans that outline a justification for a diagnosis, a thoughtful planned approach to psychopharmacological interventions, and the monitoring of specific clinical indicators to determine the efficacy of the prescribed medication (J2, J8, J13).

17. The facility must consider options for implementing a formal neuropsychiatric clinic consultation. It would be helpful for the facility to learn how other centers are addressing necessary interaction between psychiatry and neurology to implement clinical coordination of care (e.g., monthly neuropsychiatric clinic. The facility needs to determine the amount of clinical neurology and psychiatry time needed via an examination of the number of individuals requiring review when prescribed medication to treat both seizures and a mental health disorder (J15).

18. Develop a recruitment/retention plan for psychiatry (J1, J2, J5, J14, J15).

19. The new lead psychiatrist (department head) should work closely with the psychiatry assistant and the medical director developing and implementing a system of psychiatric care and services with other disciplines (i.e., neurology consultations) as outlined in the Settlement Agreement. The lead psychiatrist should develop a system level of integration between the psychiatric practitioners and psychology staff (J2, J3, J4, J8, J9, J15).

20. All lists and data submitted to the monitoring team must include a time frame of when the data were collected, date, title, and department submitting the information on the document. Numerous documents received by the monitoring team were not dated, did not have the name of the individual on each page submitted, therefore, it was difficult for the monitoring team to interpret percentages of completion of tasks within the time frame since the last monitoring visit (J3, J4, J6, J7, J11).

21. The facility to address the deficits as outlined in the report regarding informed consent process for psychotropic medications (i.e., prescribing practitioner responsibility; revision of consent form to include all of the necessary components). In an effort to address the deficit regarding informed consent practices, it is recommended that the facility also consult with the state office that, in turn, may want to consider a statewide policy and procedure outlining how to obtain appropriate informed consent that comply with Texas state law and generally accepted medical practice (J14).

22. To adequately complete self-assessments, collect data such as number and percentage of meetings attended by the psychiatric staff (i.e., ISPs, ISPAs, PBSPs, etc.). The psychiatric database lists the dates of the individual's ISP and BSP and the psychiatrist assigned to the individual's care, but did not specify if the psychiatrist was present or not at the meetings (J3, J9).

23. Consider the use of typed notes, projectors for review of the clinic data, and other means of making the psychiatric service provision more efficient (J2, J10, J13).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Positive Behavior Support Plans (PBSPs) for: • Individual #222 (6/14/12), Individual #216 (6/1/12), Individual #311 (6/21/12), Individual #251 (10/5/12), Individual #154 (8/20/12), Individual #386 (6/12/12), Individual #170 (11/20/12), Individual #41 (6/29/12), Individual #60 (6/1/12), Individual #239 (9/6/12) o Functional Assessments for: • Individual #251 (9/12/12), Individual #100 (9/5/12), Individual #375 (9/26/12), Individual #1 (9/26/12), Individual #94 (9/27/12), Individual #145 (6/8/12), Individual #129 (9/10/12), Individual #59 (8/23/12), Individual #162 (8/8/12), Individual #154 (7/25/12) o Six months of notes on PBSPs progress for: • Individual #222 (6/14/12), Individual #216 (6/1/12), Individual #311 (6/21/12), Individual #251 (10/5/12), Individual #154 (8/20/12), Individual #386 (6/12/12) o Annual Psychological updates for: • Individual #207 (7/24/12), Individual #125 (7/17/12), Individual #50 (9/4/12), Individual #294 (9/1/12), Individual #400 (8/6/12), Individual #267 (8/17/12), Individual #11 (9/14/12), Individual #183 (9/24/12) o Full Psychological Assessment for: • Individual #197 (8/4/12) o Sessions Treatment Plans for: • Individual #174, Individual #365, Individual #169, Individual #125, Individual #114, Individual #163, Individual #377, Individual #314, Individual #317, Individual #391, Individual #35, Individual #353, Individual #29, Individual #52, Individual #117, Individual #258, Individual #190 o Sessions Progress summaries for: • Individual #35, Individual #353, Individual #258 o Minutes of Internal and External Peer Review meetings during the last six months o Minutes of psychology meetings during the last six months o Status of enrollment in BCBA coursework for all psychology staff, undated o SGSSLC Self-Assessment, dated 11/19/12 o SGSSLC Action Plan, dated 11/16/12 o A list of individuals with PBSPs including dates of last plan revision and last review date, undated o A summary of treatment integrity, IOA, and data collection reliability, dated 9/12 o List of individuals with psychological assessments, including date of most recent assessment, undated

	o List of individuals with functional assessments, including date of most recent functional assessment, undated o PBSP Competency Assessment, undated o A list of all training conducted on PBSPs, undated o A list of all individuals who are receiving counseling/psychotherapy, dated 9/28/12 o Section K Presentation book, undated o Scan Data Card Monitoring sheet, dated 8/7/12 o Behavioral Support Monitoring Tool, 7/10/12 o Behavior Support Monitoring Tool data for September, 2012 o SGSSLC Monthly Psychology Progress note review, dated 9/6/12 o Quality Assurance Report for November 2012, Section K <u>Interviews and Meetings Held</u>: o Robb Weiss, Psy.D., Chief Psychologist; John Church, Assistant Chief Psychologist; Lynn Zaruba, BCBA Clinical Supervisor o Dana Robertson, Section C Lead o Robb Weiss, Psy.D., Chief Psychologist o John Church, Assistant Chief Psychologist o Lynn Zaruba, BCBA Clinical Supervisor o Patricia Trout, Cedric Woodruff, Amanda Rodriquez, Unit Directors <u>Observations Conducted</u>: o Psychology Department Meeting o PBSP training (12/4/12) • Instructor: Amanda Bankston, Associate Psychologist • PBSP trained: Individual #170 o Psychiatry Clinic Rounds (12/4/12) • Attending Psychiatrist: Dr. Draksharam • Individual Presented: Individual #37 o Psychiatry Clinic Rounds (12/4/12) • Attending Psychiatrist: Dr. Bazzell • Individual Presented: Individual #200 o Sex Offender Treatment Team (SOTP) staff meeting o Psychology Internal Peer Review Committee • Individual presented: Individual #38 o Behavior Support Plan Committee (BSPC) Meeting • Individuals presented: Individual #283, Individual #291, Individual #100 o Functional Assessment review meeting • Individual presented: Individual #346 o Behavioral Systems task group • Staff present: Daryle Barnes, Associate Psychologist; Sim Nyakunika, Associate

	Psychologist; Erick Ybarra, Associate Psychologist; Dr. Weiss, Chief Psychologist, John Church, Assistant Chief Psychologist; Lynn Zaruba, BCBA Clinical Supervisor o SOTP Therapy session • Five individuals o Observations occurred in various day programs and residences at SGSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals
	Facility Self-Assessment: Overall, the self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared based directly on the monitoring team's report. SGSSLC's self-assessment consistently included a review for each provision item, a list of the activities engaged in by the monitoring team, the topics the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This allowed the psychology department and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team wants to acknowledge the efforts of the psychology department in completing the self-assessment, and believes that they are proceeding in the right direction. SGSSLC's self-assessment indicated compliance for items K2, K3, and K8, and noncompliance for all other items of this provision. The monitoring team's review of this provision, as detailed below in this report, was congruent with the facility's self-assessment. Finally, the self-assessment established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur throughout the facility, and because it will likely take some time for SGSSLC to make these changes, the monitoring team continues to recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Although no additional items were found to be in substantial compliance, there were several improvements since the last onsite review. These included: • Development of data collection reliability (K4) • Improvements in the comprehensiveness of the progress notes (K4) • Demonstration of data-based decisions in interdisciplinary meetings (K4) • Increase in the percentage of functional assessments for individuals with PBSPs (K5)

	• Improvement in the comprehensiveness of the functional assessments (K5) • Increase in the percentage of individuals with annual psychological updates (K7) • Development of a method for the collection of treatment integrity (K11) The areas that the monitoring team suggests that SGSSLC work on for the next onsite review are: • Ensure that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Ensure that replacement/alternative behaviors are collected and graphed for each individual with a PBSP (K4) • Establish minimal frequencies of data collection reliability (K4) • Establish minimal acceptable data collection reliability levels, and demonstrate that those levels are achieved (K4) • Initiate the collection of interobserver agreement (IOA) (K4, K10) • Increase the number of individuals with functional assessments (K5) • Increase the number of individuals with annual psychological assessments (K7) • Ensure that all Positive Behavior Support Plans (PBSPs) are consistent with the hypothesized function of the target behavior (K9) • Establish minimal frequencies for the assessment of treatment integrity (K11) • Establish minimal acceptable treatment integrity levels, and demonstrate that those levels are achieved (K11)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the professionals in the psychology department who wrote positive behavior support plans (PBSPs) were demonstrably competent in applied behavior analysis as evidenced by the absence of professional certification, as well as by the lack of consistent comprehensiveness of some behavioral programming (e.g., see K5 and K9) observed at the facility. At the time of the onsite review, one associate psychologist was a BCBA, and five associate psychologists had completed BCBA coursework and were completing supervision requirements. Twelve of 13 associate psychologists who wrote PBSPs (92%) were either enrolled in, or completed, coursework toward attaining a BCBA. This compares with the last review when 92% of the associate psychologists that wrote PBSPs were either enrolled in or completed BCBA coursework. The facility provided supervision of psychologists enrolled in the BCBA program by the on-staff BCBA. SGSSLC and DADS are to be commended for their continued efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance

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K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility continued to be in substantial compliance with this item. The director of psychology (chief psychologist) had a Psy.D. and was licensed in several states, including Texas. He was a member of the Psychological Association of Greater West Texas, and had over 15 years of experience working with individuals with intellectual disabilities. Additionally, under Dr. Weiss' leadership, several initiatives had begun toward the attainment of substantial compliance with provision K	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The facility continued to be in substantial compliance with this item. SGSSLC continued its weekly internal, and monthly external, peer review meetings. The peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected or were new to the facility. The peer review meetings also allowed more time to discuss cases. In addition to the peer review meetings, the facility conducted Behavior Support Plan Committee (BSPC) meetings that contained many of the elements of internal peer review, though these meetings continued to only review PBSPs that required annual approval. The facility also added a weekly meeting that reviewed functional assessments. The internal peer review meeting observed by the monitoring team reviewed Individual #38's PBSP. The peer review meeting included active participation from the majority of the department's associate psychologists, and appeared to result in the identification of several new interventions to address Individual #38's target behaviors. Review of minutes from internal peer review meetings indicated that the majority of psychologists in the department regularly attended peer review meetings. Additionally, meeting minutes indicated that internal peer review meetings consistently occurred weekly, and that once a month, these meetings included a participant from outside the facility, thereby achieving the requirement of monthly external peer review meetings. Operating procedures for both internal and external peer review committees were established. The monitoring team will review meeting minutes to ensure that internal peer review consistently occurs weekly, and external peer review consistently occurs at least monthly to maintain substantial compliance with this provision item.	Substantial Compliance

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K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted continued improvements in this provision item that are discussed in detail below. In order to achieve substantial compliance, however, the facility needs to modify the method used to collect interobserver agreement (IOA), establish acceptable data collection reliability and IOA frequencies and levels, and demonstrate that those frequencies and levels are achieved. Additionally, the facility needs to expand the collection and graphing of replacement/alternative behaviors to all individuals with a PBSP. Finally, SGSSLC needs to ensure that, when individuals are not making expected progress, the progress note or PBSP consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred. As discussed in the last report, the facility used a PBSP data collection system that included the use of scan cards. Scan cards were preprinted individual cards, containing categories of target behaviors that direct care professionals (DCPs) used to record target behaviors. The cards could then be scanned and used to produce graphs of the data. As reported in the last review, however, not all individuals' replacement behaviors were being collected at the time of the onsite review. None of the 14 data sheets reviewed by the monitoring team had replacement data. Additionally, although four of 10 PBSPs reviewed contained replacement behavior graphs, three of the graphs were blank (i.e., did not contain replacement data). It is recommended that the occurrence of replacement/alternative behaviors be collected for all individuals with PBSPs. The ease of implementation and the simple process from data collection to graphing were clear advantages of this scan card system of data collection. Additionally, the data system required DCPs to record a predetermined code in each recording interval (15 minutes) if target or replacement behaviors did not occur. This procedure ensured that the absence of target behaviors in any given interval did not occur because staff forgot to record the data. This requirement also allowed for the review of data cards to determine if DCPs were recording data at the intervals specified (i.e., data collection reliability) when the observations by psychologists or management occurred mid-shift. The monitoring team did its own data collection reliability by sampling individual scan cards across several homes, and noting if data were recorded up to the previous hour. The target behaviors sampled for six of 14 scan cards reviewed (43%) were completed within the previous 60 minutes (three cards had data that were not completed for 1 to 2 hours, and three other cards did not contain data for the entire shift). This represented a decrease from the last review when 100% of the scan cards were completed within 60 minutes of the behavior occurring. At the time of the onsite review, the facility was conducting data collection reliability for approximately 50% of the PBSPs. Their data, however, was somewhat higher than that	Noncompliance

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		found by the monitoring team. September 2012's data collection reliability data, for example, represented 21 PBSPs and indicated that 81% of the scan cards were filled out within 60 minutes of the observation time. The monitoring team will attempt to collect data collection reliability with members of the psychology department in future reviews in order to better understand the discrepancy between the department's scores and the monitoring team's. At this point it is recommended that the facility establish minimum frequencies for the collection of data collection reliability (i.e., how often it is collected), and ensure that those frequencies occur. Additionally, minimum data collection reliability levels should be established (i.e., what are acceptable data collection reliability scores), and the facility should ensure that those levels are achieved. The usefulness of this form of data collection reliability is limited to observations made in the treatment site (that is, simply reviewing completed data sheets would not indicate when they were filled out), however, being in the treatment site and providing feedback to DCPs will likely improve the timeliness of data recording at SGSSLC. The facility had also recently begun the collection of IOA measures. As discussed in the last report, while data collection reliability assesses whether data are recorded, IOA data assess if multiple people agree that a target or replacement behavior occurred. Review of the method of IOA collection with the department indicated that the methodology initiated should be modified to simplify the collection of IOA. It is recommended that the facility establish minimum acceptable frequencies of IOA collection and specific IOA goals (i.e., how high does IOA need to be), and ensure that these frequencies of IOA collection and levels are attained. As recommended in past reviews, all the graphs reviewed by the monitoring team were simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events. The routine use of data to make treatment decisions also continued to improve. For example, in Individual #37's psychiatric review, the associate psychologist presented graphs that were current (the graphs represented data that occurred up to three days prior to the clinic meeting) and simple to understand. They clearly showed the effects of a move to a new home. The clear and current graphs contributed to a productive discussion by Individual #37's team, and to data based decisions concerning the use of his medications and various treatment interventions. In reviewing PBSP data for seven individuals (Individual #60, Individual #41, and Individual #170's PBSPs did not contain current data for severe target behaviors behavior), three (43%) indicated a lack of progress in at least one severe target behavior. This was consistent from the last review when 40% of PBSPs reviewed indicated a lack of	

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		progress. An area of improvement for the facility is the documentation of action taken to address the lack of progress. In two of the three individuals for whom there was no obvious progress in severe target behaviors (67%), available progress notes clearly documented specific staff actions to address the absence of target behavior change. This represented an increase from the last review when none of the progress notes reviewed documented actions to address the absence of progress. Examples of action documented in the progress note to address lack of progress were: • Individual #154's progress note suggested that his increase in physical aggression and self-injurious behavior were related to a recent move of homes resulting in less space to move about independently, and the absence of sensory equipment that Individual #154 used in his previous home. His progress note indicated that staff were now attempting to establish a space for Individual #154 to be independent in his new home, and were moving his sensory equipment to his new home. • Individual #251's April 2012 progress note indicated that his physical aggression was most likely to occur in the morning. The progress note went on to propose a review of his sleep data to determine if the absence of sleep was affecting his increase in dangerous behavior. Not all progress notes reviewed, however, indicated that some activity (e.g., retraining of staff, modification of PBSP) had occurred in response to an individual not making expected progress. For example, Individual #222's August 2012 progress note documented an increase in physical aggression, however, no action was noted. It is recommended that in those instances when an individual is not making expected progress, that the progress note or PBSP consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred. The monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at SGSSLC.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for each individual, and the absence of functional assessments for each individual with a PBSP. Additionally, as described below, several of the functional assessments reviewed were not judged to be complete. <u>Psychological Assessments</u> A list of all individuals and dates of their full psychological assessments indicated that 37 of the 223 individuals at the facility (17%) did not have a full psychological assessment. This represented a slight decrease from the last review when 11% of individuals did not have full psychological assessments. One full psychological assessment was completed since the last review. This psychological assessment was reviewed to evaluate its	Noncompliance

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		comprehensiveness. The full psychological assessment reviewed was judged to be complete and included an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. It is recommended, however, that all individuals at SGSSLC have a full psychological assessment. <u>Functional Assessments</u> A spreadsheet provided to the monitoring team indicated that 42 of the 203 individuals with PBSPs (21%) had functional assessments. All individuals with a PBSP should have a functional assessment of the variable or variables affecting their target behaviors. Thirty-six functional assessments were completed since the last review. Ten of these functional assessments (28%) were reviewed to assess compliance with this provision item. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures can contribute to understanding why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. All of the functional assessments reviewed included acceptable indirect assessment procedures. Six (i.e., Individual #100, Individual #94, Individual #145, Individual #59, Individual #375, and Individual #162) of the 10 functional assessments reviewed (60%) were judged to contain adequate direct assessment procedures. This represented an improvement from the last review when at least 10 functional assessments were available for review (i.e., May 2011), when none of direct observation procedures were judged to be acceptable. An example of a complete direct assessment procedure is described below: • Individual #100's functional assessment included a direct observation that included his aggressive behavior, and a clear example of staff attention and Individual #100's access to a desired activity following the aggression. One of functional assessments reviewed (i.e., Individual #129) did not include a direct observation. The other three functional assessments rated as unacceptable (i.e., Individual #1, Individual #251, and Individual #154) included direct observations, but did not include an example of the target behavior and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. All functional assessments should include direct observations (unless the frequency of the target occurs at such a low frequency that it is impractical to	

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		observe) that include target behaviors and provide additional information about the variables affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. When comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Seven of the 10 functional assessments reviewed (70%) were judged to have a clear summary statement. This was another substantial improvement from the May 2011 review when only 10% of the functional assessments reviewed were found to have a clear summary statement. One functional assessment (i.e., Individual #251) did not have a summary statement. The other two functional assessments rated with unacceptable summary statements (i.e., Individual #94 and Individual #129) included precursors to target behaviors and staff interventions, but labeled them as potential antecedents and consequences of the target behavior. For example: • Individual #94's summary statement lists "she begins walking briskly…" as an antecedent to physical aggression. • Individual #129's summary statement lists "relocation to another area, away from the peer she is having difficulty with" as a consequence of physical aggression. There was no evidence that functional assessments at SGSSLC were reviewed and modified when an individual did not meet treatment expectations. It is recommended that when new information is learned concerning the variables affecting an individual's target behaviors, that they be included in a revision of the functional assessment as soon as possible (rather than waiting until the annual review). Additionally, all functional assessments should be reviewed at least annually. Five of the 10 functional assessments reviewed (50%) were evaluated to be comprehensive and clear (Individual #100, Individual #375, Individual #145, Individual #59, and Individual #162). This represented another dramatic improvement over the May 2011 review when none of the functional assessments reviewed were evaluated as acceptable.	

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K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	The majority of SGSSLC's initial (full) psychological assessments were not current and, therefore, this provision item was rated as being in noncompliance. Only seven of the 186 individuals with full psychological assessments (4%) were conducted in the last five years. This is the same percentage of individuals with current psychological assessments reported in the last review. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the initial or full psychological assessment, an annual update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should contain the elements identified in K5 and comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. A list of annual updates indicated that 102 of the 223 individuals (46%) at SGSSLC had current (written within the last 12 months) annual updates. This represented a substantial improvement from the last review when 16% of individuals had annual updates. All individuals should have an annual update. Thirty-nine annual updates were competed in the last six months, and eight of these (21%) were reviewed to access their comprehensiveness. All eight of the annual assessments reviewed (100%) contained all of the components described in K5. This represents an improvement in the comprehensiveness of annual assessments from the last review when (92%) were judged to be complete. Finally, initial psychological assessments should be conducted within 30 days for newly admitted individuals. The facility indicated that two of the four recent admissions (50%) to the facility (in October of 2012) had initial psychological assessments within 30 days of admission.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be	The facility continued to be in substantial compliance with this item. As discussed in the last review, multiple therapies and psycho-educational classes, and individual therapies were offered at SGSSLC. Seventeen individual treatment plans and three progress summaries were reviewed to assess compliance with this provision item. Additionally, the monitoring team observed a group therapy session and attended the sex offender treatment team (SOTP) staff meeting.	Substantial Compliance

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	measured to determine the efficacy of treatment.	All treatment plans reviewed were found to be goal directed, with measurable objectives, specific treatment expectations, and appeared to be derived from evidence-based practices. They also contained an objective review of progress, and each treatment plan reviewed included a "fail criterion" and a plan for the generalization of acquired skills. Observations of the group therapy session indicated that there were clear objectives for the observed session, measurable progress toward those goals were recorded, and the therapy reflected evidence-based practices. Staff who provided therapeutic interventions were qualified to do so through specialized training, certification, or supervised practice. Staff who assisted in therapy, or who supervised homework or milieu activities, received training and monitoring from qualified therapists. Finally, the facility developed a referral form that documented the need for services. In order to maintain substantial compliance the facility will need to demonstrate that all non-PBSP therapies continue to be goal directed, with measurable objectives, specific treatment expectations, objective measures of progress, a fail criterion, and a plan for generalization of skills learned during therapy. Additionally, the facility will need to demonstrate that their therapies are evidence based and steps have been taken (e.g., attended conferences, workshops, modified curriculums) to ensure that all therapies represent current best practices.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility	This item was rated as being in noncompliance because the majority of PBSPs were not updated (at least annually), and several of those reviewed did not contain interventions that were based on functional assessment results. A list of individuals with PBSPs indicated that 203 individuals at SGSSLC had PBSPs. One hundred and fifteen of these (57%) were more than 12 months old. This compared with the last review when 58% of PBSPs were more than 12 months old. All PBSPs should be reviewed when necessary, and at least annually. Forty-two PBSPs were completed since the last review, and 10 (24%) of these were reviewed to evaluate compliance with this provision item. All 10 of the PBSPs reviewed had the necessary consent and approvals, and there was evidence that seven of these (70%), were implemented within 14 days of receiving necessary approvals and consents. As found in the last review, all PBSPs reviewed included descriptions of target behaviors, and all of these were operational (100%). All 10 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors. Nine of these PBSPs (Individual #170 was the exception)	Noncompliance

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	Superintendent may grant a written extension based on extraordinary circumstances.	specified the reinforcement of functional replacement/alternative behaviors as potentially effective antecedent procedures. Six (60%) of the PBSPs reviewed (i.e., Individual #216, Individual #170, Individual #154, Individual #239, Individual #222, and Individual #251), however, contained generic sounding interventions (i.e., verbal prompt, redirection, and relocation) that appeared to be inconsistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This represented a decrease in the effectiveness of antecedent and consequent procedures reported in the last review when 40% were judged to be inconsistent with the stated function. An example of a consequent intervention potentially incompatible with the hypothesized function was: • Individual #216's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities), and staff attention. The antecedent procedure was consistent with his hypothesized function and included prompting Individual #216 to tell staff that he wanted to be left alone, and providing positive attention when he complied with staff requests. The consequent interventions in Individual #216's PBSP, however, included staff attending to him (verbal prompt) and removing him from the environment following an episode of physical aggression (relocation). If, however, avoiding undesired situations and staff attention were reinforcing for Individual #216 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of his disruptive behavior. Encouraging (and allowing) him to indicate that he wanted to leave the area BEFORE he engaged in physical aggression represented an effective antecedent intervention. After the targeted behavior occurred, however, Individual #216 should not be allowed to escape the undesired activity until he appropriately requests it, and staff attention kept to a minimal. If the nature of his undesired behavior is such that it is dangerous to maintain him in the activity, then the PBSP should specify his return to the activity when he is calm, and again encourage him to escape or avoid the demand by using desired forms of communication (i.e., replacement behavior) before he engages in physical aggression. The PBSP needs to clearly state that removal of the undesired activity and staff attention should be avoided following the target behaviors, whenever possible and practical, because it encourages future undesired behavior. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #60s' PBSP hypothesized that the function of his aggressive behavior was to gain others' attention. Antecedent interventions included providing him with staff attention for the absence of target behaviors, and	

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		encouraging/reinforcing him for engaging in his replacement behavior (i.e., asking to shake staff's hand) before he was aggressive. His intervention following aggression included ensuring safety, but minimizing attention to Individual #60, and staff extending their hands to prompt the replacement behavior. Although some staff attention is typically necessary following the target behavior to ensure safety, it is important that the PBSP clarify for DCPs that attention following the target behavior needs to be minimized, and will be consistently available following the replacement behavior. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. As discussed above, replacement behaviors were included in all of PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified, and providing the reinforcer for alternative behavior is practical. The monitoring team found that replacement behaviors were functional in nine of the 10 PBSPs with replacement behaviors that could be functional (90%). This represented a slight decrease from the last report when 100% of all replacement behaviors that could be functional were functional. The replacement behavior that was not functional was: • Individual #170's PBSP hypothesized that her physical aggression was maintained by positive reinforcement (i.e., attention from others and access to preferred items). Her replacement behavior was practicing deep breathing relaxation. Relaxation is incompatible with Individual #170's aggressive behavior and, therefore, likely an appropriate activity for her, however, it did not appear to be functional. Examples of a functional replacement behavior could be teaching her alternative ways to attain attention (such as asking to talk to staff), and preferred items. All nine of the functional replacement behaviors discussed above appeared to be behaviors already in the individual's repertoire and, therefore, the PBSP instructions were more related to actions staff needed to complete rather than skills the individual needed to acquire. For replacement behaviors that are already in the individual's repertoire, a SAP would not be required. Based only on the reading of the PBSP, the monitoring team can only speculate as to if these replacement behaviors were in the individual's repertoire, or if they required the acquisition of a new behavior. The purpose of introducing this distinction is that when the replacement behavior requires the acquisition of a new behavior, it should be written	

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		in the new format skill acquisition plan (SAP, see S1). Finally, as reported in the last review, in all PBSPs reviewed (100%) the reinforcement of functional replacement behaviors was included in the PBSP. Overall, four of the 10 PBSPs reviewed (40%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors (when possible and practical), and clear, concise antecedent and consequent interventions based on the results of the functional assessment (Individual #311, Individual #386, Individual #41, and Individual #60). This represented a decrease from the last review when 60% of the PBSPs reviewed were judged to be complete.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	As discussed in K4, the monitoring team suggested that the facility modify their method of collection of IOA data. In order to achieve substantial compliance with this provision item, a system to regularly assess, track, and maintain minimum levels of agreement of PBSP data (i.e., IOA) across the entire facility will need to be demonstrated. Target behaviors were consistently graphed, and replacement behaviors were beginning to be graphed at SGSSLC (see K4). It is recommended that replacement/alternative behaviors be graphed for all individuals with PBSPs. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path. As discussed in K4, the quality and usefulness of these graphs continued to improve.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	An area of improvement since the last review was the initiation of the collection of treatment integrity at SGSSLC. This provision item was rated as being in noncompliance, however, because at the time of the onsite review, treatment integrity was not consistently collected and tracked for each PBSP. SGSSLC continued to monitor PBSPs to ensure that they were written so that DCPs could understand and implement them. As discussed in the last review, one way to increase the likelihood that PBSPs are implemented as written is to reduce the number of target behaviors on each plan. None of the 10 PBSPs reviewed had more than five target behaviors. This represented an improvement from the last review when 20% of the PBSPs reviewed contained six or more target behaviors. The only way to ensure that PBSPs are implemented with integrity, however, is to regularly collect treatment integrity data. The facility began collecting treatment integrity data in August 2012. At the time of the onsite review, treatment integrity data were collected in 55% of the	Noncompliance

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		homes at SGSSLC (according to September 2012 data). The monitoring team attended a work group meeting discussing the new treatment integrity methodology. SGSSLC was utilizing a comprehensive treatment integrity tool that collected treatment integrity data on both antecedent and consequent components of the PBSP, along with data on the implementation of replacement behaviors. The monitoring team believes this treatment integrity tool will satisfy the requirements of this provision item. In order to achieve substantial compliance with this provision item, the facility needs to identify minimal frequencies of the collection of treatment integrity, establish minimal treatment integrity levels, an ensure that those frequencies and levels are achieved.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	This item was rated as being in noncompliance because, at the time of the onsite review, the facility did not have documentation that staff assigned to an individual was trained to competency on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Psychologists and psychology assistants conducted the trainings prior to PBSP implementation and whenever plans changed. In order to meet the requirements of this provision item, the facility will need to present documentation that staff assigned to work with an individual (including float staff) has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. Additionally, there needs to be evidence that the training included a competency-based component. Finally, the facility should track DCPs who require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP. The monitoring team observed the training of DCPs on Individual #170's PBSP. The training included a review of the PBSP by the associate psychologist, an opportunity for DCPs to ask questions covering varying aspects of the PBSP, and written questions pertinent to Individual #170's PBSP. The training did not, however, include a competency based training component that allowed the psychologist to observe the staff implementing the plan, and an opportunity for the psychologist to provide performance feedback to the DCPs. As discussed in K11, at the time of the onsite review, the facility was conducting these direct observations following some of the trainings. It is therefore recommended that the facility expand the competency-based component (i.e., treatment integrity) to all trainings.	Noncompliance

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K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SGSSLC had a census of 223 individuals and employed 13 psychologists responsible for writing PBSPs. Additionally, the facility employed three psychology technicians and four psychology assistants to assist those psychologists. As discussed in K1, the facility had one psychologist with a BCBA. In order to achieve substantial compliance with this provision item, the facility must have at least eight psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who write Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. Replacement/alternative behaviors should be collected and graphed for all individuals with PBSPs (K4, K10).
3. Establish minimum frequencies for the collection of data collection reliability (i.e., how often it is collected), and ensure that those frequencies occur (K4).
4. Establish minimum data collection reliability levels (i.e., what are acceptable data collection reliability scores), and ensure that those goals are achieved (K4).
5. Modify the methodology used collect IOA (K4).
6. Establish minimum acceptable frequencies of IOA collection, and ensure that those frequencies occur (K4).
7. Establish specific IOA goals (i.e., how high does IOA need to be), and ensure that these levels of IOA are attained (K4).
8. In those instances when an individual is not making expecting progress, the progress note or PBSP should consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).
9. Ensure that all individuals have a full psychological assessment (K5).
10. Ensure that all individuals with a PBSP have a functional assessment of the variable or variables affecting their target behaviors (K5).
11. All functional assessments should include direct observations (unless the frequency of the target occurs at such a low frequency that it is impractical to observe) of target behaviors and provide additional information about the variables affecting the target behavior (K5).

12. Ensure that each functional assessment has a clear summary statement that integrates information for direct and indirect assessments into a comprehensive plan that will guide the development of the PBSP (K5).

13. When new information is learned concerning the variables affecting an individual's target behaviors, it should be included in a revision of the functional assessment (with a maximum of one year between reviews for all functional assessments) as soon as possible (K5).

14. All full psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).

15. All individuals should have an annual update (K7).

16. Ensure that initial psychological assessments are conducted within 30 days for all newly admitted individuals (K7).

17. All PBSPs should be reviewed when necessary, and at least annually (K9).

18. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior (K9).

19. Expand treatment integrity to each PBSP, establish minimum frequencies for the assessment of treatment integrity collection, establish minimal treatment integrity levels, and work with DCPs to ensure that those levels are achieved (K11).

20. The facility needs to provide documentation that all staff assigned to work with an individual (including float staff) have been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter. This training should include a competency-based component. Additionally, the facility should track DCPs that require remediation, and document that they have been retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP (K12).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 4/19/12 o DADS Policy Preventive Health Care Guidelines, 8/30/11 o DADS Policy #006.2: At Risk Individuals, 12/29/10 o DADS Policy #09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044.2: Emergency Response, 9/7/11 o DADS Clinical Guidelines o SSLC Medical Services Policy, 4/26/12 o Infection Control Committee Meeting Minutes, 2012 o Clinical Daily Provider Meeting Minutes o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Primary Provider CME Data o Mortality Review Documents o Clinic Tracking Spreadsheets o Reports for Internal and External Medical Reviews o Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD o Listing, Individuals hospitalized and sent to emergency department o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #59, Individual #196, Individual #104, Individual #391, Individual #193 Individual #153 Individual #389 Individual #24, Individual #178, Individual #52 o Annual Medical Assessments the following individuals: • Individual #380, Individual #250, Individual #325, Individual #140, Individual #175,

	Individual #164, Individual #310, Individual #218, Individual #399, Individual #247, Individual #203, Individual #16, Individual #55, Individual #190, Individual #239 o Annual Medical Assessments, Consults, Labs, APL, Nutrition Assessments, QDRRs for the following individuals: • Individual #179, Individual #379, Individual #163, Individual #46, Individual #77 o Neurology Notes for the following individuals: • Individual #26 Individual #294, Individual #23, Individual #241 Individual #345, Individual #312, Individual #273, Individual #153, Individual #288 Individual #386 o Consultation Referrals and IPNs and for the following individuals: • Individual #328, Individual #251, Individual #273, Individual #180, Individual #45 <u>Interviews and Meetings Held</u>: o Joel Bessman, MD, Acting Medical Director o Scott Lindsey, APRN, FNP, Medical Administrative Director o John Burnside, MD, Primary Care Physician o Albert Fierro, RN, Medical Compliance Nurse o William Bazzell, MD, Psychiatrist o Angela Gardner, RN, Chief Nurse Executive o Lisa Owens, RN, Quality Enhancement Nurse o David Ann Knight, RN, Quality Enhancement Nurse o Angela Kissko, QA Director o Charles Njemanze, Facility Director <u>Observations Conducted</u>: o Daily Medical Provider Meetings o Pneumonia Review Meeting o Administrative IDT Meeting o Observations of homes
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) the provision action information. The center's medical administrative director served as the lead for this provision. For each provision item, he provided a series of activities engaged in to conduct the self-assessment. For provision L1, he looked at compliance with annual assessments, ER/hospital audits, Quarterly Medical Summary tracking, meeting agendas, and data from the preventive care databases. Data were reported for the first two items, but no data were available for the last two items. The final component was the determination of the self-rating. Similar activities were completed for the other three provision items. The self-assessment was reviewed provision by provision over a period of several days during the compliance reviews. The types of activities the monitoring team engages in were discussed at length. In moving forward, the center lead should

	review this report noting the recommendations and comments included in the body of the report. The next self-assessment should include some measure of assessment for every item reviewed by the monitoring team. It should also include other activities believed to be important in the self-assessment process, too. This type of an assessment will help to determine the status of the facility relative to compliance. It will also provide a clearer picture of what actions need to occur to move towards substantial compliance. The facility rated itself in noncompliance with all four provisions. The monitoring team concurred with the facility's self-ratings.
	Summary of Monitor's Assessment: At the time of the compliance review, medical services were provided by two full time providers, a full time locum provider, and one part time locum provider. In the face of this staffing challenge, they were able to make progress. Much of the progress was seen in the revision of systems, how services would be delivered, and progress monitored. The starting point was to determine the status of each individual and current systems through a series of record audits, tracking of various documents, and policy review. Record audit data were entered into databases and this information was utilized in an ongoing manner to improve compliance with preventive care screenings. Required assessments were tracked and formats revised to comply with the Settlement Agreement requirements. The daily medical provider meeting continued and the topics expanded. Consultations were now discussed each day. The facility director, medical, and nursing leaders conducted their first meeting with the local hospital. This was intended to improve communication regarding service issues. Individuals received basic medical services, such as immunizations, vision, and hearing screenings. There were small increases in the rates of most cancer screenings. As noted in previous reviews, the long-term medical staff knew the individuals very well and demonstrated genuine concern about their well being. However, problems were noted in follow-up of acute issues, overuse of verbal orders, lack of monitoring for the use of psychotropic agents, and the inappropriate use of standard operating procedures to provide medical treatment. Compliance with annual assessments improved over time, but quarterly assessments were not completed. IPN entries were generally written in SOAP format and overall the quality of the documentation had improved. External and internal medical audits were conducted. Medical management audits were also conducted. Corrective action plans were implemented for both. The medical audits remained focused on processes with no assessment of the clinical outcomes for individuals. There was little information provided on follow-up of corrective action plans. The mortality system continued to lack a reliable means of resolving problems that were discovered in the various reviews. Equally as concerning was the failure of the system to actually capture and take note of the concerns mentioned in the reviews completed within the facility.

	There had not been a great deal of work done in the areas of developing a medical quality program or in developing additional policies and procedures. Much of the work done, such as improving compliance with preventive care, was in fact contributing to improving quality. While the facility had a great deal of work to do, the medical staff appeared willing to accept the challenge. However, moving forward will require stability in the medical staff and greater continuity of care for the individuals at the facility. It will be critical to address the medical staffing issues by hiring a permanent medical director and allowing the caseloads of the two full time providers to decrease to below 100.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical department underwent a series of staffing changes over the past six months. The advanced practiced registered nurse resumed employment on 7/1/12 and with the resignation of the medical director on 9/30/12, he assumed the role of the medical administrative director. The other full-time primary provider served as the acting medical director. At the time of the compliance review, the facility had two full time medical providers (employees) and a full time locum tenens provider. The long-term locum tenens physician who worked every other week continued his duties, which varied, but primarily consisted of completing annual assessments, performing cervical cancer screenings, and providing coverage as needed. The medical compliance nurse continued in his role and assumed the lead for section G. **Physician Participation In Team Process** The medical staff conducted medical rounds throughout the day, participated in annual meetings, and in various other meetings as required. The facility continued the daily 4:30 pm daily medical meetings. The medical director facilitated these meetings, which were attended by multiple disciplines, including the medical staff, medical compliance nurse, nursing representatives, clinical pharmacist, hospital liaison nurse, psychology, dental representatives, dietary representative, and residential services. The monitoring team attended several of these meetings and observed that the process provided a forum for sharing information regarding events that occurred over the past 24 hours, including hospitalizations, emergency department evaluations, emergency restraints, consultations, and other emergent issues.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The monitoring team noted that the facility continued to believe that 4:30 pm was the only time that this meeting could occur. However, other SSLCs with similar activities conducted similar meetings in the morning because meetings of this nature typically provide the most value when they occur at the beginning of the day. The timing of the meeting should be reconsidered when the medical department is fully staffed. **Overview of the Provision of Medical Services** The medical staff conducted rounds in the homes of the individuals. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite ophthalmology and shoe clinics once a month. Podiatry clinic was held twice a month. Dental clinic was conducted daily. Individuals who required neurology services were seen off campus. There was currently no process to have a joint neurology–psychiatry clinic. Individuals who needed acute care and/or admission were usually admitted to the local Shannon Medical Center. During the last review, the monitoring team was concerned about the lack of communication between the facility and Shannon Hospital. In an effort to improve communication between the facilities, in October 2012, the SGSSLC facility director and clinical leaders met with the executive management of Shannon Hospital to discuss how the two facilities could work cooperatively to better serve the individuals. This meeting was going to occur on a regular basis, with the meeting location alternating between the two facilities. Facility staff indicated that this was a productive meeting. Labs were drawn at the facility and sent to Shannon Medical Center. Results for routine labs were returned within one to two days while the results for stat labs were available in about two hours. A mobile x-ray company completed roentgenograms and a disc was provided for viewing immediately following completion. After hours, roentgenograms were completed through emergency department assessment at the local hospital. This was a reasonable arrangement. Throughout the week, the monitoring team engaged in many discussions with both regular primary providers. They described the efforts that were being made to restructure the department. This was difficult because each maintained caseloads of over one hundred, and clinical care was their primary responsibility. Improvement was seen in some areas, such as neurological follow-up care. There continued to be an over reliance on verbal orders, although timely signing of these orders improved. Some problems showed little improvement, such as the use of standard operating procedures to provide treatment. As noted in the last review, many individuals received treatment for conditions that warranted review by a medical provider, but this did not occur. The	

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		medical staff were sometimes never notified that the treatments were provided. Follow-up of individuals continued to be less than optimal. In many instances, individuals returned from the hospital and were seen once, but were not evaluated again for several days. Stability in medical staffing, continuity, and lowering of caseloads will be needed in order to see improvement in many areas. The various sections of this report will provide examples of both the high and low points noted during this review. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 9 of 10 (90%) AMAs were current • 8 of 9 (89%) AMAs included comments on family history • 8 of 9 (89%) AMAs included information about smoking and/or substance abuse history • 8 of 9 (89%) AMAs included information regarding the potential to transition The record for Individual #52 did not include an Annual Medical Assessment. It could not be determined if the AMAs in the record sample were completed within 365 days of the previous assessment because the previous assessment date was not known. For the purpose of this review, the AMA was considered timely if it was completed within 365 days of the previous summary. The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous years assessment. For the sample of Annual Medical Assessments submitted by the facility: • 9 of 15 (60%) AMAs were completed in a timely manner • 14 of 15 (93%) AMAs included comments on family history • 14 of 15 (93%)AMAs included information about smoking and/or substance abuse history • 13 of 15 (87%) AMAs included information regarding the potential to transition	

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		The facility tracked compliance with the timeliness of the assessments. The average compliance rate for the months of June 2012 through September 2012 was 89%. The format of the annual assessments was revised to include a template of preventive care. This required the primary provider to document the required preventive care in each annual review. A plan of care (management plan) and discussion of risk, when appropriate, was required for each problem. This was a very significant improvement in the annual assessment process. The assessment was now titled the "Annual Physician Exam and Summary." Most of the assessments in the record sample were completed in the old format. Overall, the assessment contained good information, including the immunization status of individuals, family histories, and detailed social histories. The improvements were seen in the more recent assessments. Additional work is needed in expanding the discussion of risk assessment and plans of care, connecting the risks, and ensuring that all active problems are included. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were not being completed by the medical staff. A template was developed, but had not been implemented at the time of the review. Given the current staffing, the plan was to begin with semi-annual summaries and progress towards the requirement of quarterly completion when staffing was increased. This appeared to be a reasonable plan given the current caseloads. <u>Active Problem List</u> For the records contained in the record sample: • 5 of 10 (50%) records included an APL The current APL format will need to be revised and there are many options for doing so. The APLs reviewed were difficult to read because as problems resolved, there was a strikethrough line and a new diagnosis was written next to it. Additionally, the documents did not appear to ever be retyped so those that were updated became virtually unreadable. The Health Care Guidelines require that the APL be updated as problems change. The frequency of re-typing the documents is facility specific, but this should be done no less than annually. The monitoring team suggests that SGSSLC review formats utilized at other SSLCs and seek guidance from state office. <u>Integrated Progress Notes</u> Physicians documented in the IPN in SOAP format. The notes were usually signed, dated, and timed. The content of the IPN entries was improved and all of the most recent entries were legible. Many were electronically generated and signed. There continued, however, to be an overall lack of documentation. That is, follow-up for	

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		acute problems and post hospitalizations was not adequate. While most individuals were seen initially after hospitalization, several days often lapsed before there was documentation of the next medical evaluation. Documentation was discussed with the medical staff during the compliance review. The medical department was aware of this problem. The average compliance with documentation requirements for ER visits and hospitalizations for the months of May 2012 through August 2012 was 79% and 63% respectively. This was based on monthly audits conducted by the medical department. <u>Physician Orders</u> Physician orders were usually signed, dated, and timed. There continued to be many verbal orders, but improvement was noted in the signing of the orders. Incomplete orders appeared to be the most frequent problem due to the lack of medication indications. One of the most troubling findings observed in the physician orders was the number of treatments administered with standard operating procedures. Many of these orders were never signed by a medical provider and, in many cases, the medical provider was never notified of the problem. These treatments continued to be provided for nausea, vomiting, diarrhea, and respiratory symptoms and some of these individuals required transport to acute care facilities within days for serious medical conditions. The facility must reevaluate how these standard operating procedures are being utilized by nursing because it appeared that this procedure had the potential to delay the provision of appropriate medical evaluation and care for some individuals. <u>Consultation Referrals</u> The consults and IPNs for five individuals were requested. A total of 45 consults completed after May 2012 (including those from the record sample) were reviewed: • 24 of 45 (53%) consultations were summarized by the medical providers in the IPN within five working days. The facility implemented a new process to document the response of providers to the recommendations of consultants. The back page of the consult was used to document acceptance of recommendation, plan of care, the need to review on rounds, and referral to the IDT. At the time of the review, the form was being used to document the response in lieu of IPN documentation, however, the Health Care Guidelines required that an entry be made in the IPN. This was discussed with the medical staff. Overall, the medical providers did a very good job summarizing the recommendations of the consultants and stating agreement or disagreement with the recommendations. In some cases, there were explanations stating the consultant would be contacted for clarification prior to making a decision. Other notes stated that issues needed to be	

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		referred to the IDT for discussion. The barrier to compliance with this requirement was related to timelines with IPN documentation rather than content of the entries. This may have been related to problems with routing and filing. The consultation referral process is discussed in further detail in section G2. **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Documentation of tetanus status was more difficult to verify. Record audits were completed to obtain data on preventive care data. These data were entered into newly developed databases that tracked preventive care and various diseases and conditions. Each week, a report was printed for use by the medical staff and case managers. This report showed studies that individuals needed to complete. Greater focus on the provision of the cancer screenings resulted in some benefits because the compliance rates increased, albeit slightly, in several areas over a relatively short period of time. Some discrepancies in data were noted, but overall this process represented a great improvement for the department. Data from the 10 record reviews listed above and the facility's preventive care reports (databases) are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 9 of 10 (90%) records included PCFSs • 5 of 9 (55%) forms were signed and dated Improvement was observed in the updating of the flowsheets. Almost every flowsheet was being updated to some degree. The flowsheet may be updated at any time. It may be practical to review the flowsheet as part of the quarterly review process and update at that time. Consideration should also be given to adding additional sections to the flowsheet for disease management, such as diabetes mellitus and osteoporosis to ensure the appropriate monitoring is completed. This would allow those preventive care requirements to be removed from the lab matrix. <u>Immunizations</u> • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 9 of 10 (90%) individuals had documentation of varicella status.	

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		Screenings • 10 of 10 (100%) individuals received appropriate vision screening • 8 of 10 (80%) individuals received appropriate hearing testing Prostate Cancer Screening • 3 of 5 males met criteria for PSA testing • 3 of 3 (100%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The total for both lists was 54 males: • 42 of 54 (72%) males had PSA results documented in 2011 or 2012 (current) • 1 of 54 (2%) males did not have current PSA results documented • 11 of 54 (25%) males had no PSA documented due to discontinuation secondary to age Breast Cancer Screening • 0 of 5 females met criteria for breast cancer screening A list of females age 40 and older was provided. The list included the names of 39 females, the date of the last mammogram, and explanations for any lack of testing: • 26 of 39 (67%) females completed breast cancer screening in 2011 or 2012 • 13 of 39 (33%) females did not have current breast cancer screening o 10 of 13 (77%) females had screening discontinued due to age o 3 of 12 (23%) females did not have screening due to refusal Cervical Cancer Screening • 5 of 5 females met criteria for cervical cancer screening • 3 of 5 (60%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 77 females, the date of the last pap smear, and explanations for lack of testing: • 46 of 77 (60%) females had documentation of cervical cancer screening within the past three years. • 8 of 77 (10%) females did not have documentation of cervical cancer screening within the past three years • 22 of 77 (29%) females had cervical cancer screening discontinued	

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		Colorectal Cancer Screening • 3 of 10 individuals met criteria for colorectal cancer screening • 1 of 3 (33%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 81 individuals: • 40 of 81 (49%) individuals had completed colonoscopies • 41 of 81 (51%) individuals had not completed colonoscopies o 3 of 81 (4%) individuals refused colonoscopy o 1 of 81 (1%) individuals had poor preps o 4 of 81 (5%) individuals had no explanation for lack of colonoscopy o 20 of 81 (25%) individuals had colonoscopies discontinued with some reason cited o 13 of 81 (16%) had colonoscopies discontinued with no reason cited Additional Discussion The colonoscopy report was divided into sections including individuals for whom colonoscopy was discontinued with justification and those without justification. In many cases, the justification was well documented. In several other cases, the justification was limited to statements, such as "suspended due to disability and need for sedation." The monitoring team recommends that the medical providers thoroughly document the discussion to discontinue or not complete required screenings. This documentation should include a risk/benefit assessment as well as the discussion with the individual/LAR and the IDT. The medical providers should ensure that the proper risk categorization is applied to determine the appropriate frequency in the case of cervical cancer screening. **Disease Management** The facility had access to numerous clinical guidelines issued by state office. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. Diabetes Mellitus Five records were reviewed for compliance with standards set by the American Diabetes Association: (1) glycemic control (HbA1c<7), (2) monitoring for diabetic nephropathy (3) annual eye examinations, and (4) administration of yearly influenza vaccination: • 5 of 5 (100%) individuals had adequate glycemic control • 5 of 5 (100%) individuals had urine microalbumin documented • 5 of 5 (100%) individuals had annual eye examinations	

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		• 5 of 5 (100%) individuals received the yearly influenza examination Additionally, four of the five individuals were receiving renal protection with administration of an ACE/ARB. One individual had been diagnosed with diabetes less than five years. The facility's database contained the names of 23 individuals with the diagnosis of diabetes. During the June 2012 visit, the facility was tracking individuals at risk for metabolic syndrome. Based on reviews of QDRRs and other documents, the medical staff will need to track the individuals who are receiving new generations antipsychotics in order to mitigate risk and implements plans. Appropriate and through monitoring was lacking for several individuals. The facility must ensure that emphasis is placed on risk assessment and mitigation prior to the development of the actual diagnosis of diabetes. The addition of risk assessments in the annual summaries should assist in these efforts. Monitoring for the risks of metabolic syndrome related to the use of antipsychotic medications is discussed in sections N2 and N3. <u>Pneumonia</u> The facility tacked the number of cases of pneumonia that occurred each month and categorized each as bacterial or aspiration. The number of cases of pneumonia for 2012 is summarized in the table below. Pneumonia 2012 | | Jan | Feb | Mar | Apr | May | Jun | July | Aug | Sep | | No. of Cases | 5 | 1 | 0 | 2 | 2 | 1 | 4 | 4 | 6 | The facility had not done any analysis of the pneumonia data to determine any special causation for the increase in incidence. During the week of the compliance review, the facility implemented a pneumonia review process. During this meeting, the case of Individual #104, who is discussed below, was reviewed. A case presentation was done by the medical director followed by a discussion of the participants who included representatives from the clinical disciplines. The result of the meeting was a plan to address some findings related to the individual as well as some systemic issues that surfaced during the discussion. This was the first meeting and the group was essentially deciding how to best format the process to move forward. The monitoring team suggests that the facility implement a comprehensive approach to the management of pneumonia inclusive of a thorough evaluation of the data, utilization the current state guidelines to develop a facility specific policy that provides more detail on identification of risk, treatment and management of individuals with recurrent aspiration, and implementation of a multidisciplinary review process. Additional details are provided in the recommendations.	

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		Case Examples Individual #52 This individual was seen by the neurologist in August 2012 for an initial evaluation. The recommendation was made to decrease the dose of carbamazepine and check labs. The daily medical provider minutes, 9/12/12, documented discussion regarding this individual's behavior. It was noted that there was increased agitation following the dose reduction. Moreover, the individual was involved in an interaction with another individual that resulted in a serious injury, fracture. The minutes also noted that the required labs ordered by psychiatry had not been done. The individual was seen again by the neurologist on 11/2/12. It was noted by the neurologist that the serum sodium normalized with the reduction, but the serum trough level was fairly high (upper limits of normal). At that time, the recommendation was made to further decrease the Tegretol to simplify the medication regimen. The consultation note, which was very detailed, did not include any discussion related to increased agitation following the dose reduction. There was discussion about leaving the management of Depakote to the discretion of the psychiatrist. This example illustrated the need to have a mechanism to integrate neurology and psychiatry for those individuals with a dual diagnosis. Individual #104 This individual had a history of dysphagia and choking which required use of the Heimlich maneuver. Dysphagiagrams dated 3/31/10 and 1/12/12 both offered the recommendation that the individual have another primary source of nutrition and hydration. The IDT elected to continue oral nutrition. Nursing documented in the IPN on 10/6/12 at 2 am that this individual had cough, coarse breath sounds, altered breathing pattern, and a pulse ox of 91%. Through SOP orders, medications were given to the individual. There was no notification of the physician and there was no follow-up nursing assessment. The next IPN entry was on 10/7/12 at 5:20 pm. The entry documented that the individual had a temperature of 101.2, HR 113, RR 22, and pulse ox of 86%. The physician was notified and a CXR was obtained which showed pneumonia. The individual was transferred to the emergency department and was diagnosed with aspiration pneumonia. The record review indicated several problems, including the immediate issue that there was no notification of a physician with implementation of the SOP. The use of SOP was seen consistently throughout the conduct of this review and, just as in this case, physicians were not notified of medical problems. This was also noted in the June 2012 compliance review. Other problems identified in the record included the lack of a recent QDRR. The last QDRR was dated 8/6/12 and it failed to adequately document the monitoring for the	

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		use of the new generation antipsychotic medications. This individual received olanzapine and the QDRR documented a weight from 5/16/11 of 224 lbs. There was no documentation of a glucose or HbA1c in the QDRR. There was no discussion of the impact of the psychotropic medications on the dysphagia. Finally, the most recent Annual Medical Assessment, completed on 4/4/12, did not include dysphagia as an active problem and, therefore, had no plan to address it. There was also no assessment of how the individuals behavior, proclivity for food stealing, history of choking, and the need to have enhanced supervision would impact the ability to successfully transition into the community. Individual #251 The IPN entry for this individual stated that the "PST and medical team all agree that sedation required for EGD and colonoscopy constitutes greater risks an likely benefits." The consultant specifically wrote that a history of colon cancer and stomach cancer in first-degree relatives. I still think it would be a good idea to do the screening exam especially with recent weight loss." The IDT should ensure that the individual's family and/or LAR is fully aware of the risks and benefits involved in the decision. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 62 individuals. The following data regarding AED use were summarized from the list provided: • 10 of 62 (16%) individuals received 2 AEDs • 3 of 62 (4%) individuals received 3 AEDs • 0 of 62 (0%) individuals received 4 AEDs • 0 of 62 (0%) individuals received 5 AEDs The number of individuals seen by the neurologist is summarized in the table. Neurology Clinics 2012 Appointments April 12 May 10 June 12 July 12 August 9 September 9 A total of 64 appointments were completed over six months. There was an average of 11 clinic appointments over the six-month period. This was a reasonable number of appointments given the number of individuals who received medications and the low rate of AED polypharmacy.	

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		The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed in the above documents reviewed section. One individual did not have the diagnosis of seizure disorder. The following is a summary of the review of the 10 records in addition to the records included in the record sample: • 9 of 11 (82%) individuals were seen at least twice over the past 12 months • 11 of 11 (100%) individuals had documentation of the seizure description • 10 of 11 (91%) individuals had documentation of current medications for seizures and dosages • 10 of 11 (91%) individuals had documentation of recent blood levels of antiepileptic medications • 0 of 11 (80%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 10 of 11 (91%) individuals had documentation of recommendations for medications • 0 of 11 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The facility reported that three individuals had refractory seizure disorder. Two of the individuals had undergone VNS implantation. The family of the third individuals was in the process of evaluating treatment options. The monitoring team continues to recommend that individuals with a diagnosis of refractory seizure disorder be referred to a qualified epileptologist for evaluation of more aggressive management. The majority of individuals reviewed in the sample submitted by the facility received the appropriate follow-up care. Three individuals in the record sample had the diagnosis of seizure disorder. All three of the individuals received follow-up as required by the neurologist. Notes from the medical provider meetings as well as consultant notes indicated problems obtaining lab studies as required. The management of the two individuals, included in the record sample, was complicated by management of their psychiatric illness. It was not always clear that the neurologist had the best information. The facility did not have an onsite neurology-psychiatry clinic. The process to capture medical and psychiatric information will need to be evaluated to determine if it is achieving the goal of assisting in improving integration of services. Overall, the care provided by the neurology consultant appeared to be valuable to the individuals. The notes were detailed and provided adequate explanations. The consultant worked with the information provided. At times, the notes reflected questions about the information given by staff that accompanied the individuals. Providing additional information on behavior and side effects might be helpful to the	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>consultant. Some of the side effect information is included in properly completed MOSES and DISCUS evaluations. To that end, the facility should provide this information to the consultant.

Do Not Resuscitate
The facility submitted a list of individuals who had DNR orders in place. The list included the names of 17 individuals who had active DNRs. This was an alpha list generated by a database. It did not provide adequate information related to the criteria for DNRs. Explanations for DNRs included reasons, such as DNR per guardian, dementia/DNR per IDT, and DNR per Guardian/IDT agrees. The ages of the individuals spanned from 28 years to 92 years.

The monitoring team has recommended in previous reviews and continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy.</td><td></td></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td><u>Medical Reviews</u>
An external medical reviewer conducted Round 6 of the medical audits in November 2012. State guidelines required that a sample of records be examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were eight essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. A five percent sample of records was audited for both regular medical providers. The data submitted by the facility are summarized in the table below:

<table>
<tr><td colspan="3">External Medical Reviews 2012</td></tr>
<tr><td></td><td>Essential</td><td>Nonessential</td></tr>
<tr><td>Round 5</td><td>92.5</td><td>84</td></tr>
<tr><td>Round 6</td><td>96.5 (79.5)</td><td>92 (68)</td></tr>
</table>
*( ) Internal reviews

Determining the significance of the scores was difficult since there were different reviewers for Round 5 and Round 6. There was also a marked difference in the internal and external scores. This should clearly prompt a review of both the evaluation tools and the training on use of the tools.

The facility provided compliance by question graphs, which showed that there was 100% compliance with all items except question #9 and question #20. This did not</td><td>Noncompliance</td></tr>
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		appear accurate because there was not 100% compliance for the essential elements, which were the first eight questions. Nonetheless, compliance rate for immunizations (question #9) and documentation of abnormal diagnostics (question #20) in the IPN were reported as 80% and 60%, respectively. In addition to the general medical reviews, Round 6 also included medical management audits for constipation, seizures, and UTIs. Medical Management Audits 2012 Constipation: 89 (100) | Seizures: 71 (88) | UTI: 75 (75) For the areas of constipation and seizure management, there was a significant variation in the scores of the reviewers with the internal reviewers scoring higher. The QA Department developed action plans for the general medical audits and medical management audits and the QA nurse completed follow-up. No data were provided on the status of the corrective action plans for Round 5 external audits. Plans for Round 6 were recently implemented. It was reported that only 50% of CAPs were completed for Round 5. Achieving substantial compliance in this provision will require that several issues are addressed: • The medical management audits will need to address clinical outcomes in addition to processes. • Corrective actions will need follow-up to closure. This should be monitored in a timely manner by the QA department. • The QA department should ensure that data are accurate. The quality process cannot be driven with inaccurate information and data. <u>Mortality Management</u> There were three deaths in 2012 at the time of the compliance review. Information from the three death certificates is summarized below: • The average age of death was 72.3 years with an age range of 32 to 93 years. • The causes of death were: (1) failure to thrive (2) hypertensive heart disease, and (3) cardiopulmonary arrest, congestive heart failure, dyslipidemia (preliminary pending autopsy report). • Two autopsies were performed. • All three individuals died at the facility.	

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		The monitoring team met with the facility director, medical director, CNE, QA director, and QA nurses to discuss mortality management at SGSSLC. Specific issues addressed during this discussion included: • Concerns that surfaced during the June 2012 review about availability of emergency medical equipment and the observation that there was no documentation of attention to this issue in the administrative death review • The lack of attention to recommendations generated by nursing reviews and the overall lack of a system for following up on recommendations • Use of the external Quantros information to address systems issues The facility director reported that a conference call was conducted with state office a few days earlier related to the Quantros recommendations and issues would be addressed. It appeared that the nursing recommendations from the April 2012 QA nursing review had received attention only recently. It was reported that in order to ensure appropriate follow-up, in the future, mortality recommendations would be reviewed in the Benchmark Meetings. While the Benchmark Meetings may be useful in many areas, the monitoring team encourages the facility to consider alternative means of follow-up for mortality issues. Ideally, the same multidisciplinary committee responsible for conducting the reviews should re-convene periodically to review mortality data and follow-up on the status of recommendations. This provision item remained in noncompliance.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The medical department was aware of the need to move forward with this provision item. Information from the medical audits was used to take corrective actions as warranted. However, changes in leadership in recent months resulted in the decision to essentially re-establish the framework for the delivery of health care services at the facility. To that end, processes, policies, and procedures were being re-evaluated. The records of every individual were also being audited to obtain data related to preventive care services, immunizations, etc. In conducting these audits, the facility's medical administrative director and medical compliance nurse were in fact gathering the types of data that were essential to developing a medical quality program. The data collected from the record audits were entered into databases that could be used to provide information on preventive care, seizure management, and a number of other conditions. There had not been any analysis of data, but as discussed in section L1, the information was utilized to ensure that individuals received timely preventive care. Small incremental gains were noted in	Noncompliance

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		several cancer screening. The medical department should track this over time. The monitoring team engaged in a lengthy discussion with the QA nurse, medical compliance nurse, and medical administrative director on the development of a medical quality program. They appeared to have a very good understanding of how this provision item related to provision items of section H - minimum common elements of clinical care, which was assigned to the QA nurse. It was good to see that this group worked collaboratively on this common goal because the QA nurse had demonstrated substantial growth in the area of medical quality and that knowledge would be valuable to the medical department in developing an adequate quality program. As discussed during the review, the facility will need to develop a comprehensive set of indicators that includes, a mix of process and outcome indicators in order to move towards substantial compliance with this provision item. Moreover, the facility will need to demonstrate that indicator data are collected, analyzed, and trended. Such analysis will define the strengths of the department as well as those areas that require improvement and need to be addressed through systems changes. This provision remained in noncompliance.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	State office issued a series of clinical guidelines and protocols on several diseases and medical conditions. Several of the state issued clinical guidelines were multidisciplinary and provided guidance to physicians, nurses, and direct care professionals. The medical department localized the general health care policies, but did not do any additional work with the clinical guidelines. The state issued policies were reviewed with the medical staff following the last compliance review. The direct care professionals and nursing staff received training on the state protocols and attendance rosters were submitted. It was difficult to determine the outstanding needs for training given the number of blanks on the roster. Each department should, if not already done, determine any outstanding training needs. The facility also submitted a disc containing the iLearn aspiration module. The medical leadership was aware of the need to move forward with revision of policies and procedures, develop, and implement new ones as well. This was included in the restructuring process that was discussed during the compliance review. The monitoring team encourages the medical staff to seek guidance from state office on matters related to the clinical guidelines. One particular example is that of eye examinations required for quetiapine use. The recommendation of the drug manufacturer is more stringent than that required by the facility's lab matrix prompting facility staff to contact an	Noncompliance

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		ophthalmology expert for an opinion related to this matter. These decisions are applied broadly to many individuals and are essentially matters of health policy that should be managed at the state level and the standard applied across all facilities. The final decisions typically result from the consensus in the recommendations of professional organizations. This provision remained in noncompliance.	

Recommendations:

1. The facility director must aggressively pursue the hiring of a full time medical director in order to allow the two full time providers to focus on clinical care and decrease their caseloads (L1).

2. The issues related to documentation should continue to be addressed:
    a. Annual Exams – The discussions on risk assessments should be expanded ensuring that related risks and problems are associated and discussed together.
    b. Quarterly Medical Summaries - The medical staff should begin utilizing the template. Completing every six months is a reasonable starting point realizing that the Health Care Guidelines requires quarterly completion for compliance.
    c. APLs – The format of the document must be revised. It also must be retyped on an annual basis.
    d. IPNs – Documentation of post hospital visits and acute issues must improve. It is recommended that requirements such as documentation for a minimum of three consecutive days following hospitalization or until stabilization or improvement is noted be implemented (L1).

3. The facility must address the use of the standard operating procedures for administration of medical treatment to individuals without the notification of a medical provider. A review and revision of this practice should be considered a priority item (L1).

4. The use of the consultation referral form must be addressed. Documentation in the IPN is required (L1).

5. A process should be developed for collection of data and management of data for the newly developed medical databases. The management of the database should not depend solely on one staff member (L1).

6. The facility must focus on the management of aspiration and aspiration pneumonia and assign a high priority to addressing the following:
    a. The Pneumonia Review Committee should be formally adopted and include a process for assessing and classifying pneumonia cases. Consideration should be given to development of a checklist to review every case of pneumonia. The checklist would attempt to better define an individual's risk and determine the likelihood of an aspiration event. This can only be accomplished through a rather rigorous review of risk, diagnostics, and the clinical events that occurred prior to the onset of illness.
    b. A process to ensure that every episode of pneumonia is captured should be developed. This may involve a monthly review of multiple data sets, such as a list of all individuals who received antibiotics for the diagnosis of pneumonia. This is necessary because not all individuals with a diagnosis of pneumonia are hospitalized or sent to the emergency department.
    c. A comprehensive set of guidelines is needed to provide guidance to the medical staff on the management of recurrent aspiration (L1).

7. The facility should identify those individuals at risk for metabolic syndrome and ensure that the appropriate monitoring occurs (L1).

8. The facility should review every individual on the DNR list and determine if the continued use of a DNR is clinically justified and meets state requirements.

9. The MOSES and DISCUS evaluations should be provided to the neurology consultants for review (L1).

10. A preliminary clinical death review should be completed within the required timeframe even when the autopsy report has not returned. The committee can re-convene upon receipt of autopsy findings. The clinical reviews should not be delayed for over 3 months pending autopsy findings.

11. The facility director should continue efforts to improve the mortality process at the facility including the addition of an objective review of medical care (L2).

12. A formal system for mortality follow-ups should be implemented to ensure that recommendations are followed to completion. The QA department should track the progress of corrective action plans.

13. The facility must develop a quality program based on a comprehensive set of process and outcome indicators in addition to the quality audits that are occurring (L3).

14. The facility must demonstrate that indicator data is collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology must be utilized to ensure remediation is achieved (L3).

15. The state issued clinical guidelines and protocols should be localized and expanded as necessary (L4)

16. The current policies, procedures, and guidelines should be reviewed to ensure that they are consistent with state issued guidelines (L4).

17. All forms, protocols, and guidelines should include an issue or revision date (L4).

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Active Record Order and Guidelines o Map of facility o An organizational chart, including titles and names of staff currently holding management positions. o New staff orientation agenda o For the Nursing Department, the number of budgeted positions, staff, unfilled positions, current FTEs, and staff to individual ratio o SGSSLC Nursing Services Policies & Procedures o SGSSLC Self-Assessment, Plan of Improvement, and Nursing Care Action Plan (updated 11/19/12) o Alphabetical list of individuals with current ISP, annual nursing assessment, and quarterly nursing assessment (due) dates o Nursing staffing reports for the last six months o The last six months, list of all individuals admitted to the Infirmary, length of stay, and diagnosis o The last six months, minutes from the following meetings: Infection Control, Environmental/Safety Committee, Specialty Nurses Meeting, Nurse Manager Meeting, Pharmacy and Therapeutics, Medication Variance Committee Meeting, o The last six months infection control reports, quality assurance/enhancement reports o List of staff members and their certification in first aid, CPR, BLS, ACLS o Training curriculum for emergency procedures o The last six months, all code blue/emergency drill reports, including recommendations and/or corrective action plans o Emergency Drill Checklists 5/1/12-11/30/12 o Locations of AEDs, suction machines, oxygen, and emergency medical equipment o All facility policies, procedures, and guidelines that directly describe the mission, vision, operations, etc. of the facility's infirmary o Infection control monitoring tools o Policies/procedures addressing infection control o Infection control letter to staff regarding membership and attendance at meetings o Infection Control Observation Reports 5/1/12 – 12/7/12 o Random Monitoring of Hand Washing Reports 5/1/12 – 12/7/12 o Job descriptions of Acute RN and Nurse Recruiter, if changed from prior review o Job description of Campus RN o Campus/Shift RN Logs for 11/1/12 – 12/7/12 o Consultation Tracking System data for 9/1/12 – 11/30/12 o Hospice Policy – current and/or draft policy o Names of individuals who have not received flu vaccine and why o Number of employees who have not receive flu vaccine and number who have not submitted a

	declination of flu vaccine o Policies and procedures related to the operations of the facility's infirmary, if changed from prior review o Pain PIT meeting minutes 6/1/12 – 11/30/12 o Enteral PIT meeting minutes 6/1/12 – 11/30/12 o List of individuals at risk of aspiration, cardiac, challenging behavior, choking, constipation, dehydration, diabetes, GI concerns, hypothermia, injury, medical concerns, osteoporosis, polypharmacy, respiratory, seizures, skin integrity, urinary tract infections, and weight o List of individuals and weights with BMI > 30 o List of individuals with weights with BMI < 20 o List of individuals on modified diets/thickened liquids o Documentation of annual consideration of resuming oral intake for individuals receiving enteral nutrition o Last six months peer reviews for Nursing Department o QA report for October 2012 – Section M only o Settlement Agreement Section M Nursing October Analysis o CNE and Program Compliance Nurse's Timeline for Rolling Out Monitoring Protocols o QA Department's Active Corrective Action Plan, pg 16-27 o Last six months mortality reviews and QI Death Reviews for Nursing for individuals who died o "Day of the Week" nurses' schedule for 9/1/12 – 11/30/12 o October 30, 2012 PET Medication Error Meeting minutes o October 2012 Analysis for Medication Administration Monitoring Tool Results o For the last six individuals who transitioned to the community, their completed nursing discharge summary o Draft ICHPs developed for Individual #48 and Individual #127 o Records of: • Individual #55, Individual #244, Individual #140, Individual #108, Individual #218, Individual #134, Individual #314, Individual #50, Individual #48, Individual #127, Individual #104, Individual #298, Individual #391, Individual #381, Individual #177, Individual #400, Individual #379, Individual #80, Individual #31, Individual #243, Individual #32 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Angela Garner o Nursing Operations Officer, Lisa Busbee o Infection Control Nurse, Courtney Daniels o QA Nurse, Lisa Owens o Hospital Liaison, Melanie Nealey o Nurse Educator, Rachel Wittich o Program Compliance Nurse, April Watson o PNMT RN, Maria DeLuna o RN CM Supervisor, Regina Haight

	o Clinic Nurse, Virginia Dooley o Skin Integrity Nurse, Sharon Gaither o ADOP, Melinda Gentry <u>Observations Conducted</u>: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 12/3/12 Medication Variance Committee Meeting o 12/5/12 CNE Meeting o 12/5/12 Weekly Medical/Nursing Meeting o 12/5/12 RN Weekly Meeting o 12/5/12 ISP for Individual #127 o 12/6/12 Enteral PIT Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment, which was updated on 11/19/12. Since the prior review, SGSSLC continued to use the revised form and format for its self-assessment process and separate the report into three separate sections. Although there were some improvements in the content of its evaluation of status toward compliance with the provisions of section M, the self-assessment continued to show that the Center Lead for section M needed more help to ensure that the activities that were engaged in to conduct the self-assessment would yield results that were adequate, appropriate, and relevant measures of progress toward compliance. For example, it would seem appropriate to reference the results of the facility's reviews of Nursing Discharge Summary forms under provision M2 rather than M1 and reviews of Medication Administration Records under provisions M6 rather than M1. It also appeared as though the activities engaged in to conduct the self-assessment were insufficient to measure progress toward compliance with the provisions of section M, especially provisions M2 through M5. The self-assessment was also almost exclusively focused on the results of the facility's monitoring reviews of processes and ratings of procedural compliance and failed to reveal evidence of an evaluation of the facility's outcomes of care to substantiate their self-ratings and show evidence of their status toward compliance with the provisions of section M. Of note, reliance upon the findings of the facility's monitoring reviews was problematic since they were of significantly limited sample size. During the conduct of the onsite review, the monitoring team reviewed the self-assessment with several facility staff members and provided some feedback on ways in which the various activities engaged in to conduct the self-assessment could be modified to promote compliance with the provision items. The monitoring team also invited the CNE to attend any and all meetings and interviews conducted during the onsite review to help provide them with as much information as possible, as well as first-hand

	observations, pertaining to the review process and outcomes. In addition, similar to the prior review, the monitoring team suggested that the facility strongly consider incorporating what the monitoring team evaluates and the activities they engage in to evaluate compliance into their self-assessment activities and ratings. The facility's self-ratings indicated that it was not in compliance and continued to need improvement in all six provisions of section M in order to meet a rating of substantial compliance. On the basis of all monitoring activities undertaken by the monitoring team, the monitoring team was in agreement with the facility's self-ratings. During the onsite review, the presentation books put together by various members of the nursing department were reviewed. Most of the information in these books were already submitted via the monitoring team's document request and already reviewed by the monitoring team in preparation for the visit.
	Summary of Monitor's Assessment: Since the prior review, it was apparent from the review of the document submission and it extended throughout the onsite review, that there were significant and positive changes occurring in the Nursing Department. Shortly after the prior review, the Assistant Director of Programs began directly supervising the Nursing Department. The ADOP took a close look at the status and functioning of the Nursing Department and swiftly and forthrightly concluded that the Nursing Department's ways of doing things were not working. So, in addition to clearly communicating her expectations for the Department's functioning and performance improvement, she began working very closely with the CNE to effect change across the Department. Over the past six months, the Nursing Department shifted from completing 12 monitoring tools of very small samples of aspects of individuals' health and nursing care to focusing on correcting specific problems that were impacting the health and safety of individuals who resided at SGSSLC. The first areas selected for improvement were: - Completing nursing assessments in a timely way, - Reducing nurses' unscheduled absences and late arrivals to work, - Completing nursing assessments of pain when individuals suffered injuries/illness, and - Improving the storage and administration of individuals' medications. The Nursing Department's Program Compliance Nurse's reviews showed improvements in all of these areas. During the monitoring team's review of the Enteral Performance Improvement Team's reports, it was revealed that they were finally able to show that, as a result of training, monitoring, and supervision, significant and sustained improvements in nurses' safe and accountable administration of enteral nutrition

	and fluids were made, and the facility was able to achieve and maintain 94-95% compliance in this area for August 2012 through November 2012. However, the ADOP, CNE, NOO, and other members of the nursing leadership team were well aware that there was much more work to be done to achieve compliance with the provisions of section M. For example, the Nursing Department had yet to develop and implement a skin integrity program. The importance of this program and the monitoring team's concern over the lack of attention that this area received by the Nursing Department for now well over a year cannot be overstated. The facility's infection prevention and control program was still not where it needed to be and although the new Infection Control Nurse appeared to be working hard to establish an effective surveillance and prevention program, she had no prior experience developing and implementing an infection prevention and control program. Nursing education initiatives were not complete. So, for example, only about 25% of the nurses received the special training in medication administration, half of the facility's RNs attended the physical assessment course, and the Mosby self-training course had not been implemented. Emergency medical equipment was still not being regularly checked to ensure that all equipment was present, available, and in working order. Every unit that was visited during the onsite review had some emergency medical equipment, but none of the checks were complete. The RN Case Management Supervisor had not been able to do her job for several months because she was covering vacant case manager positions, thus, it was clearly reported that absent the support, guidance, and supervision of RN case managers, there was little to no progress made in improving the content and quality of nursing assessments and plans. Also, it was plainly clear that IDTs continued to need more training and assistance with the implementation of the Integrated Risk Rating and Health Care Planning processes. The ISP meeting that was attended by the monitoring team went of for four and a half hours, however, it failed to include identification of the individual's health goals and interventions to achieve these goals, which was the essence of the individual's Integrated Health Care Plan. And last, but certainly not least, there were more vacancies in the Nursing Department than there were six months ago. Approximately 30% of the positions in the Department were vacant. Without a doubt, nursing shortages and turnover will continue to undermine positive change, morale, and the facility's expectations for its nurses to consistently and reliably implement accepted standards of nursing care. The recent changes in leadership in the Nursing Department have made a big difference and noticeable difference. This difference was observed, reported, etc. in one way or another, across the all provisions of section M. However, the Nursing Department needs to move forward with a sense of urgency in the areas of infection prevention and control, skin integrity, and risk assessment and health planning.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	SGSSLC's section M Action Plan (11/16/12) indicated that, since the prior review, all of the action steps that were underway during the prior review were completed; and only one action step – "providing follow-up training as needed based on audit data," – was "in process." According to the facility's self-assessment, since the prior monitoring review, the Nursing Department had begun to refocus its monitoring systems and started implementing targeted reviews and actions to address specific problems in the facility's delivery of nursing services and supports. For example, the results of their self-monitoring of nurses' attendance and tardiness revealed modest reduction in nurses' unscheduled absence and lateness from 90 to 73 and from 28 to 24, respectively. In addition, the facility's review of documentation related to post-hospitalization/ER/LTAC nursing assessments revealed that since July 2012, post-hospitalization/ET/LTAC nursing assessments were slightly more likely to be completed, case managers were significantly more likely to document their follow-up assessments of the individuals, and acute care plans were more likely to be completed. Notwithstanding these improvements, the facility reported that this provision item was not in substantial compliance because "documentation continues to be a factor with all tools, assessments are not being completed appropriately, and follow through is not evident." The monitoring team agreed with the facility's finding of noncompliance, but continued to based its rating on findings that failed to reveal substantial evidence of the presence and adequacy of assessment, reporting, documenting, planning, communicating, monitoring, and evaluating significant changes in individuals' health status sufficient to help ensure that the changes were readily identified and addressed. During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, most residential areas were visited at least once, observations of nursing care were made, 19 nurses were interviewed, and 21 individuals' records were reviewed. <u>Staffing, Structure, and Supervision</u> The Nursing Department reported that since the prior review, the rate of vacancies and turnover had increased. Of note, as of the review, there were reportedly 15 vacant LVN and eight vacant RN positions, five of which were RN case managers and an Acute RN. A review of the Nursing Department's database of minimum staffing levels revealed that, since the prior review, the monthly rate of days without at least a minimum number of nursing staff present and on-duty increased from 17% to 68%. As noted in all prior reviews, the daily use of overtime and nurses covering other homes persisted. Further examination of the Nursing Department's own daily staffing data and schedules for the	Noncompliance

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		three-month period of September 2012 through November 2012 revealed other sobering statistics. For example: • Each month, from one-third to two-thirds of the time, nurses on one or more homes were working overtime. • On average, 80% of the days of the month, there were one or more unscheduled absences. • In September 2012 and October 2012, 42% to 47% of the days of the month, there was only one nurse on duty to cover the entire campus during the hours of 10 pm to 6 am. Notably, yet inexplicably, this statistic improved during the month of November 2012. • Over the three-month period, there was only one day when there was no use of overtime, no unscheduled absence, and more than one nurse on duty from 10 pm to 6 am. • As noted during all prior reviews, the Nursing Department continued to fail to have a policy and procedure in place to address minimum staffing and use of agency/contract nurses to ensure that the deployment of nursing staff members across the campus was conducted in a manner that best met the health needs and risks of the individuals. On a positive note, since the prior review, the ADOP assumed oversight of the Nursing Department and direct supervision of the CNE. During the monitoring team's interview with the ADOP, she candidly reported that after the prior review, she clearly communicated her expectations for the performance and progress of Nursing Department toward achievement of substantial compliance with the provisions of section M. One by one, the ADOP met with the facility's nurses, shared her vision for the department, listened to their concerns, and took swift actions to break down barriers that stood in the way of performance improvement and compliance with the Settlement Agreement and Health Care Guidelines. The changes in the culture of the Nursing Department and the conduct of its nurses, which were immediately noticeable and palpable across all aspects and phases of the review, appeared to be the direct result of the support, guidance, direction, and leadership of the facility's ADOP. <u>Recordkeeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. The format of nurses' notes was mostly in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol. Individuals' notebooks were present on their homes and available to direct caregivers. Notwithstanding these positive findings and the quality assurance checks of the records prior to their submission to the monitoring team, there were a number of recordkeeping and documentation problems found in the 21 records selected and submitted by the facility for review, which raised question regarding the	

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		state and maintenance of the individuals' records on the units. For example: • Approximately one-third of the sample individuals' records had Active Problem Lists that were documented on top of and over pre-existing medical evaluations. A good example of this problem was found in the record of Individual #243, who had a "Problem List" that was written over and on top of her 1/27/10 Admission Evaluation, making it near impossible to decipher her current active medical problems, medications, diet, and past medical history. • Three of the sample individuals' records had no current, annual ISPs. • Two of the two sample individuals who underwent the newest ISP, IRRF, and IHCP processes failed to have complete, albeit draft, IHCPs that included interventions to address their health needs and risks. • Strikingly, 17 of the 21 sample individuals' records had one or more significantly delayed and/or missing quarterly and/or annual comprehensive nursing assessments. For many of these individuals, assessments were delayed six-plus months, and for a significant minority of these individuals, the failure to have current, comprehensive nursing assessments completed and filed in their records jeopardized their health and safety. In addition, as noted in all prior reviews, there continued to be entries that were documented on the margins of the IPNs versus starting a new page, obliterated and partially obliterated entries usually due to nurses' who attempted to write over incorrect entries of dates, times, and findings with corrected/revised information, and a significant minority of nurses' names and credentials continued to be illegible. This was an especially problematic documentation issue because it made it difficult, if not impossible, to know when critically important nursing assessments were conducted and when/if certain, specific nursing interventions were delivered. <u>Hospitalization and Hospital Liaison Activities</u> According to the state's 5/11/11 Nursing Services Policy, "The State Center Nursing Department will ensure continuity of the planning, development, coordination, and evaluation of nursing/medical needs for all individuals admitted to or discharged from the hospital to the infirmary or moving between facilities. The hospital liaison will make periodic visits to a hospitalized individual to obtain as much up-to-date information as possible from the hospital nurse responsible for care of the individual. Information gained will include but not be limited to diagnosis, symptoms, medications being given, lab work, radiological studies, procedures done or scheduled with outcomes, and plans for discharge back to the State Center." Three of the 21 individuals selected for in-depth review were hospitalized during the period of 5/1/12 – 10/31/12 for treatment of significant changes in their health. In	

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		accordance with the state's clear policy directives and the provisions of the Settlement Agreement, all of the individuals who were hospitalized had Hospital Liaison Reports and IPNs documented by the nurse Hospital Liaison filed in their records. These reports revealed evidence that the nurse Hospital Liaison periodically visited the individuals, reviewed their hospital records, interviewed their tertiary care providers, and reported to SGSSLC interdisciplinary team members the hospitalized individuals' health status, response to treatment, and progress toward discharge. The monitoring team review revealed that hospitalized individuals continued to benefit from the oversight of the nurse Hospital Liaison. For example, Individual #104 was a 59-year-old man with severe intellectual disabilities and communication deficits. During his seven-day hospitalization, he was visited three times by the Hospital Liaison. During one visit, the Hospital Liaison noted that Individual #104 was "hard to arouse" and was refusing to eat his meals. These findings prompted the Hospital Liaison to call Individual #104's hospital nurse and to address his apparent sedation. In addition, the Hospital Liaison facilitated a doctor-to-doctor review of Individual #104's condition, which resulted in a medical plan of care to further address his carbon dioxide levels in preparation for his planned discharge to SGSSLC. As noted during the prior review, the nurse Hospital Liaison continued to carry out her role and responsibilities with strong commitment and dedication to promoting quality care. For example, the nurse Hospital Liaison continued to chair the facility's Ethics Committee and attend the facility's Human Rights Committee (HRC). In addition, since the prior review, the nurse Hospital Liaison assumed additional roles/responsibilities, to continue to make a difference in the lives of the individuals served by the facility. The nurse Hospital Liaison was attending Partner's Meetings with the facility's director and tertiary care providers' representatives to resolve problems and create solutions, like policies and procedures, to address potentially difficult situations, such as the recently drafted Sitter/Patient Advocate policy that addressed the role and responsibilities of the facility's direct care staff members when they were at the bedside of hospitalized individuals. In addition, since the prior review, the nurse Hospital Liaison took over the responsibility of facilitating and tracking individuals' off-campus medical appointments and consultations. Thus, when an individual was hospitalized, the nurse Hospital Liaison identified what medical appointments and consultations were pending, she informed the hospitalist of her findings, and she helped ensure that, if possible, the individual received his/her medically-necessary tests, appointments, consultations, diagnostic procedures, etc. while he/she was in the hospital. Last, but not least, the nurse Hospital Liaison continued to participate in IDT meetings that were held post-hospitalization to help teams identify and address the health needs and risks of the individual. For example, the nurse Hospital Liaison reported that she attended Individual #178's IDT meeting post-hospitalization and helped his team address his diet and nutrition needs through sharing	

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		her observations of Individual #178's food intake and assessment of his meal preferences. Of note, SGSSLC should address the lapses in follow-up and oversight of hospitalized individuals that occurred when the nurse Hospital Liaison was not on duty. Although the nurse Hospital Liaison reported to the monitoring team that the CNE was designated as her back-up nurse, there was no evidence in any of the hospitalized individuals' records that this backing up had occurred as reported. <u>Wound/Skin Integrity</u> According to the state's 5/11/11 Nursing Services Policy, "Individuals will be provided with nursing services in accordance with their identified needs…[and] nursing services includes participation in a Skin Integrity Committee that includes medical, dietary, nursing, specialized therapy, pharmacy, quality assurance, and residential services staff. The committee reviews data related to skin integrity issues, analyzes data for patterns and formulates recommendations for preventative measures and management." Neither the facility's action plan nor the facility's self-assessment for section M referenced follow-up to the 2/14/12 provision action item, which stated, "A dedicated nurse to create a committee and be responsible for skin integrity issues and conduct quarterly meetings was identified." However, at the time of the review, the CNE reported that, since the prior review, the Unit III Nurse Manager was assigned the responsibility for developing a system, process, and procedures to address individuals' skin integrity issues and creating and leading the Skin Integrity Committee. During the monitoring team's meeting with the Unit III Nurse Manager, it was clear that the activities undertaken to develop this important aspect of identifying, assessing, notifying physicians, monitoring, intervening, and keeping appropriate records of this important aspect of the delivery of health supports and services were few and far between. For example, the Unit III Nurse Manager reported that, over the past six months, she reviewed the facility's May 2012 incident reports, spoke to the PNMT RN and reviewed her notes, reviewed another SSLC's skin integrity tracking system and reports of their data, and tried to get access to Avatar. In September 2012 and October 2012, the Unit III Nurse Manager held two Skin Integrity Team meetings. There were only two other nurses that attended these meetings, and no outcomes emerged as a result of the meetings or the aforementioned Unit III Nurse Manager's activities. Thus, as noted in the prior review, the PNMT's weekly reviews of changes in individuals' health status continued to be the place where individuals with alteration in skin integrity, which were identified and referred to the PNMT, were reviewed. Notwithstanding the PNMT's dutiful oversight of some individuals' altered skin integrity,	

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		a review of the documents submitted by the facility and information obtained during the onsite activities revealed several problems, which were shared with the CNE, NOO, Director of Rehabilitation, and PNMT RN during the review. For example, in response to the monitoring team's request for information about the individuals who suffered alteration in skin integrity over the past six months, such as the name of the individual(s), type of skin integrity issue(s), and date(s)of onset and resolution of the problem, only five individuals reportedly suffered stage I and stage II decubiti in May 2012 through July, 2012, no individuals suffered skin integrity issues in August 2012 through September 2012, and no data were provided for October 2012 through November 2012. A comparison of these data with the results of the monitoring team's review of the 21 sample individuals' records revealed that, over the past six months, one-third of the sample individuals suffered alteration(s) in skin integrity, such as abscesses, cellulitis, pilonidal cyst, breakdown on coccyx, gluteal cleft, and lower back, etc., but not one was referenced by the facility's list. <u>Infection Control</u> During the prior review, it was noted that there continued to be serious problems and failures in the facility's infection prevention and control program. Procedures and protocols for infection prevention and control were not adequately developed and implemented, in six months, only one Infection Control Committee meeting was held, no longitudinal, historical, or contextual data were prepared or discussed at the Infection Control Committee meeting, a large number of staff had not complied with the state's and facility's policy regarding TB skin tests, the Infection Control Nurse had not been provided with the tools she needed to do her job, and on-going surveillance, such as monitoring of hand washing, completing monthly infection control rounds and monitoring tools, and reviewing staff members' compliance with infection control procedures at mealtime, were not consistently or adequately implemented. The facility's provision action information, plan of action, and self-assessment indicated that, since the prior review, significant and sustained actions were taken to improve employees' compliance with TB testing. Thus, as of the review, there were no employees who were delinquent, except for the employees who were out on extended leave. This was a significant and notable improvement from the findings of the prior review. However, there continued to be many more challenges facing the newly hired Infection Control Nurse, who formerly worked as the RN case manager for homes 505 and 508. For example, like the former Infection Control Nurse, the new Infection Control Nurse had no prior experience in the field of infection prevention and control. Thus, over the little less than one month that the Infection Control Nurse was in her new job, she conducted some internet research on how to enroll in on-line continuing education	

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		courses in infection prevention and control, started entering data into a new immunization database that would eventually serve as the facility's most complete and comprehensive source of information regarding individuals' and employees' immunization histories, received and reviewed antibiotic order sheets from the pharmacy, and conducted spot checks of employees compliance with hand washing procedures. During the monitoring team's interview with the Infection Control Nurse, she reported that she planned to continue conducting spot checks of hand washing and would soon implement a protocol where evening and night shift nurses would conduct and complete Infection Control Observation Reports. Given the facility's self-proclaimed critical nursing shortage, especially on the evening and night shifts, it was unclear how this protocol would or could be implemented in the near future. A review of the various observation and monitoring reports submitted by the facility revealed the following: • Although the facility reported that they conducted three Infection Control Observation Reports a month, during the six-month period of 6/1/12-11/30/12, only six Infection Control Observation Reports were completed and submitted for review. • A review of the Infection Control Observation Reports revealed that despite the severity of the problems identified during the infection control reviews, there was no evidence of follow-up to resolution. For example, homes were cited for visibly soiled refrigerators and freezers, spoiled food in the refrigerator, dirty clothes on the floors, empty soap dispensers, direct care staff members who failed to wash their hands after they were soiled, dirty shower and bathroom areas, etc. However, as of the review, the statuses of the corrective actions were unknown. • There continued to be no analysis of staff members' compliance with infection control procedures during the conduct of mealtime monitoring activities. Thus, it remained unclear to the monitoring team, what actions, if any, were taken in response to staff members and individuals who failed to carry out proper infection prevention and control procedures before, during, and after meals. • The facility continued to submit 150 pages of dozens of infection control polices and procedures that were developed over five to 12 years ago and not reviewed since 2007-2008 as evidence of the facility's policies and procedures addressing infection control (see document submission X.17.a-c.). Many of these policies and procedures called for practices that were no longer implemented by clinical professionals or in effect at the facility. For example, the policy for "Taking Vital Signs in Isolation," called for glass thermometers to be used and then sterilized by the Medical Supply/Infection Control department, the policy for Cleaning a	

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		Thermometer After Use" called for wiping it with a tissue and placing it in a container of iodine, the policy for "Proper Sanitizing of the Dining Areas" called for cleaning of the water coolers inside and out every day, and so on. • The one Infection Control Committee meeting where minutes were documented was held on 9/11/12. As noted in the prior review, there was no evidence that longitudinal, historical, or contextual data were prepared or discussed at the Infection Control Committee meeting. Thus, there was no evidence of the committee's discussions of patterns or trends during the facility's review of infections and antibiotic use. Of note, the only plan of action that the committee put forward to address all but one type of infection suffered by individuals who resided at the facility, was to "Continue monitoring." • During the review of 21 individuals' records, there was no evidence that the Infection Control Nurse was consistently informed of or involved in the plans to address incidents that posed risks for possible transmission of contagious diseases. For example: o There was no evidence that the Infection Control Nurse was informed and/or involved in addressing the health needs and risks of two individuals who suffered human bite wounds. o There was also no evidence that the Infection Control Nurse participated in the development of the health care plan to meet the needs of a newly admitted, 25-year-old, sexually active woman, who was diagnosed with a sexually transmitted disease • During the review of the facility's data regarding the administration of flu vaccination, in accordance with the facility's Pandemic Respiratory Infectious Disease Readiness Plan, it was revealed that four individuals had not received the flu vaccination, but there was documentation of their reasons for declining the vaccination. The review of employees, however, revealed that over one-third of employees had not received the flu vaccination with over 80% failing to provide documentation of their declination. According to the facility's policy, home LVNs and RNs, the Infection Control Nurse, Campus Shift RNs, the clinic nurse, and other nurses designated by the CNE will conduct vaccination clinics in order to administer the vaccination to individuals and staff members. In addition, the Infection Control Nurse was the person assigned responsibility for tracking both the number of staff vaccinated as well as the number of staff that declined. It was unclear whether and/or when flu vaccination clinics were held and what, if any, follow-up had occurred.	

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		Emergency Response Another opportunity for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to ensure that they and other staff members were adequately and appropriately trained and competent to respond to actual medical emergencies via mock medical emergency drills. During the monitoring review of the presence, availability, and functioning of medical emergency equipment, it was noted that since the prior review, there were some improvements in the presence and availability of medical emergency equipment in areas where the majority of the individuals resided. However, a review of five randomly selected living areas revealed that although suction machines, oxygen, emergency equipment, backboards, and AEDs were present, they were not checked on a daily basis. In addition, the location of suction machines, oxygen, emergency equipment, backboards, and AEDs was not consistent across units, sometimes the equipment bags/supplies were dirty and covered with dust, and/or stored under other assorted discarded supplies and personal belongings. A review of the past six months of Emergency Drill Checklists and revealed that nurses participated in most drills, other clinical professionals participated occasionally, and, on average, 90-100% of the drills conducted were passed. Drills were not passed when direct care staff members and/or nurses were not familiar with the location and use of medical emergency equipment. On all occasions when Drill Instructors requested that Nurse Managers follow-up with staff members who failed a drill, there was evidence that they ensured that follow-up occurred, and usually did so within 24 hours of the drill. Infirmary Another way for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to provide health care to individuals who were residing in the facility's infirmary. As noted in the prior review, the SGSSLC infirmary had five beds. During the five-month period of 5/1/12-9/30/12, the facility reported that there were only 18 admissions to the infirmary, with an average length of stay of 3.3 days. Since the prior review, the Acute RN position was vacant. Thus, the oversight of the delivery of nursing supports and services to individuals residing in the infirmary fell to the Unit Nurse Manager. Since the prior review, there were no changes made to the policies and procedures related to the operations of the facility's infirmary. Thus, the mission, vision, purpose, scope, operations, and management of the facility's infirmary continued to be	

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		operationalized by three 2001 policies that pertained to medical care plans and admissions to and transfers to/from the infirmary that had not been reviewed/revised since 2005, one 2010 policy regarding the responsibilities of the individuals' IDTs when they were admitted to the infirmary, and four protocols pertaining to choking, pre- and post-sedation monitoring, acute illness/injury, hospitalization/transfer/discharge, and the role of the nurse Hospital Liaison. During the monitoring team's interview with the Acute RN, it was also reported that there were no standardized evaluations of acuity that assisted clinical professionals with determining who would, or should, be admitted to the infirmary. Rather, admissions to the infirmary were based solely upon the preferences of the individuals' treating physician. Thus, it continued to be the case that if two individuals presented with similar acute health needs and levels of health risk, depending upon the preference of the individuals' treating physician, one could be assessed, treated, and monitored on his/her home unit and the other admitted to the infirmary, assessed, and monitored by the nurses assigned to unit 516W. A review of the 21 sample individuals revealed that, over the past six months, half of the 21 individuals were transferred to/from the emergency room, discharged from the hospital, and/or residents of the infirmary. Overall, a review of their records revealed that eight of the 10 individuals failed to receive complete nursing assessments, as prescribed by the Post-Hospital/ER/LTAC nursing assessment protocol, and no evidence that daily, acute assessments were performed by their nurses until their acute health needs were stable and/or resolved. <u>Other Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the state's Nursing Services Policy stipulated that nursing staff members must document all health care issues and must have follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem has resolved. Across the 21 individuals reviewed, there was evidence that their physicians usually responded to their nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen. However, as noted in all prior reviews, direct care staff members were usually the first responders and reporters of health care problems and concerns to the LVNs. Thus, there continued to be a heavy	

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		reliance upon the direct care staff members to readily identify problems and the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to RNs for assessment, monitoring, and referral to the physician. A review of 21 sample individuals' records showed numerous examples of the facility's failure to ensure that its nurses consistently identified, implemented, and documented their interventions to address individuals' health care problems and changes in health status, and/or conducted at least daily follow-up until resolution of the significant changes in individuals' health status occurred. The following examples represented the seriousness of this problem at SGSSLC. • On 10/1/12, Individual #80 complained of a cough and congestion. His nurse obtained his vital signs, listened to his lung sounds, administered cough medicine and phenylephrine 10 mg, told Individual #80 that these medications were "PRN and need to be asked for," and "encouraged him to drink plenty of water to thin [his] secretions and notify his nurse of productive cough." There was no evidence of Individual #80 nurses' follow-up to his change in health status until 10/4/12, when he stated, "I don't feel good, my chest hurts, and my cough is bad." Individual #80 was emergently transferred to the hospital with a temperature of 105 degrees. • On 7/19/12, Individual #31's direct care staff member reported that she was confused and had diarrhea for five days. At this time Individual #31's nurse noted that she complained of abdominal pain had altered thought process and the potential for dehydration as a result of her diarrhea. Individual #31's nurses notified her doctor, administered an antidiarrheal, drew blood for lab tests, and planned to continue to monitor her for further changes in her health status. Nonetheless, there was no evidence of any follow-up to Individual #31's change in health status. • On 10/18/12, Individual #244's direct care staff member reported that she was having a seizure. Individual #244's nurse noted that she found Individual #244 on the stairs, her upper extremities were shaking and her eyes were rapidly moving for four minutes. Individual #244's nurse's assessment indicated that she was at "risk for trauma related to neurologic effects and noncompliance related to Depakote refusal." Individual #244's physician was notified of this significant change in her health status, and although her physician requested that Individual #244 be observed and any signs of seizure activity be reported, there was no evidence of any follow-up monitoring and/or assessment by Individual #244's nurses.	

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M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In accordance with the provisions of the Settlement Agreement, the DADS Nursing Services Policy and Procedures affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized comprehensive nursing assessment forms in use at SGSSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. In addition, a review of the state's guidelines for completing the comprehensive nursing assessments revealed that they clearly required the comprehensive nursing assessments to be completed prior to and in anticipation of the individuals' annual and quarterly ISP meetings. Thus, making it imperative that the Nursing and QDDPs/ISP Coordination Departments closely coordinate, communicate, and collaborate with each other. According to the facility's self-assessment, their reviews of the completion rates of annual and quarterly nursing assessments revealed that one-half to three-fourths of the nursing assessments that were due were not completed. Thus, the facility concluded that this provision item was not in substantial compliance because assessments continued to be delinquent and/or not completed in a timely manner. The monitoring team's review of 21 sample individuals' records revealed that 17 of the 21 sample individuals' records had one or more significantly delayed and/or missing quarterly and/or annual comprehensive nursing assessments. For many of these individuals, assessments were delayed six-plus months and, for a significant minority of these individuals, the failures of their nurses to complete and filed current, comprehensive nursing assessments in their records jeopardized their health and safety. This represented a significant decline in performance from the prior review when six of 21 sample individuals failed to have current annual and/or quarterly nursing assessments filed in their records. Of the remaining three individuals who had timely comprehensive annual and quarterly nursing assessments filed in their records, only one individual's comprehensive nursing assessment was complete, accurate, and a reasonably adequate portrayal of the health status of the individual (Individual #108). The problems referenced above significantly and negatively impacted the development of individuals' Health Management Plans (HMPs) and the selection of interventions to achieve outcomes, which were unfortunately based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. As a result, a rating of noncompliance was given to this provision item.	Noncompliance

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		Examples are given below: <u>Regarding specific individuals</u> • During the onsite review, the new Integrated Health Care Planning Process was reportedly in effect and implemented for Individual #48 and Individual #127. However, a review of their records revealed that Individual #48's most current comprehensive nursing assessment was completed almost four months prior to her ISP meeting and development of her IHCP, and Individual #127 failed to have comprehensive nursing assessments completed during the 13-month period of 10/31/11 to 11/26/12. • Individual #391 was a 22-year-old woman who was morbidly obese and diagnosed with hypertension, polycystic ovary syndrome, and, over the past several months suffered episodes of bilateral otitis media and menorrhagia. Individual #391's 8/10/12 and 12/5/12 comprehensive nursing assessments were copied almost verbatim from one of her prior assessments. Thus, they both referenced the outcomes of meal monitoring observations that reportedly occurred on 5/1/12, and both had the same blank entries carried over from one quarterly review to the next. Thus, Individual #391's 12/5/12 list of nursing diagnoses failed to capture a complete and accurate inventory of her health problems, needs, and risks and failed to result in an adequate health care plan that addressed and met her needs. • Individual #55 was a 20-year-old woman who, on 5/30/12, was discharged to a group home. In September 2012, she was readmitted to SGSSLC. Her 10/15/12 (re)admission comprehensive nursing assessment completely disregarded her failed group home placement as a relevant psychosocial health need/risk and failed to reference any health event and/or outcome that may have occurred and/or impacted her health during the four months she was away from the facility. Curiously, Individual #55's nurse's summary/analysis of her health status from previous quarterly and annual reviews failed to reference any of the relevant findings from the assessment completed prior to her discharge, and was limited to the phrase, "New admission." <u>Regarding numerous individuals</u> • Individuals' weekly Aspiration Trigger Assessment reports and health status tracking logs were not consistently completed or reviewed by nurses as part of the assessment process. • The overwhelming majority (80%) of the individuals' Post-Hospitalization/ER/LTAC Nursing Assessments were incomplete. • As noted in all prior reviews, the impact of many of the individuals' chronic conditions were either not adequately portrayed by the individuals' nursing	

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		assessments and/or not even referenced in the individuals' lists of nursing diagnoses. • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status. This was noted when individuals suffered unplanned weight loss or weight gain. • Lists of nursing problems/diagnoses were incomplete and usually copied verbatim from prior assessments regardless of changes suffered by the individual during the review period. • As noted in the prior review, there continued to be evidence of the practice of copying over from one review period to the next particular assessment activities, such as meal monitoring, and similar patterns of blank entries across individuals' assessments. This called into question the validity and reliability of the assessment process, especially since nurses signed and dated the assessments attesting to the fact that they had indeed performed/completed all aspects of the assessment and provided the results of their assessments to the individuals' QDDPs and other IDT members. • The five discharge nursing summaries that were reviewed were in need of improvement. They were not in the same form/format, they were not complete, they failed to referenced complete lists of the individuals' health problems, needs, and risks, and they all failed to provide even a basis, minimal description of the individuals' participation in their health care and explain their progress/lack of progress toward the achievement of their desired health goals.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of interventions. In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regarding to planning, they must actively participate in ISPA meetings and IDT meetings to discuss and formulate plans of care to address the health risks, as well as other chronic and acute health needs or issues as they arise, for the individuals served by the facility. The guidelines also indicated that RN case managers were not to provide RN coverage for the unit/campus on any shift, not to be scheduled to work or provide RN coverage for the unit/campus on weekends or holidays, not to work as a campus RN, RN supervisor or Office on Duty, and not to provide supervision to other nurses. Thus, while the guidelines confirmed expectations for RN	Noncompliance

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		case managers, they also sought to ensure that RN case managers would be afforded adequate time and attention to focus on their main task – the quality, clinically optimal, and cost-effective management of the health care status and health care needs of individuals on their assigned caseloads. The facility reported during its opening presentation that since the prior review, on 11/2/12, there was training for two IDTs on the newly enhanced risk processes, including the Integrated Health Care Plans, by the facility's QDDP Coordinator, CNE, and RN Case Manager Supervisor. Further, the facility stated that during the onsite review, the monitoring team would observe firsthand the newly enhanced risk processes in action and demonstrated by two IDTs. As the facility continues to implement its enhanced risk processes, which included the development of Integrated Health Care Plans (IHCPs), compliance with this provision item will be affected by nurses' ability to successfully transition the development of individuals' health care plans from the HMP model to the IHCP version of the process, which portends to be a higher level of collaborative plan development with interconnected roles/responsibilities for the implementation of planned interventions to achieve specific, measurable, attainable, realistic, and timely goals. According to the facility's action plan for section M3, since the prior review, there were two action steps that continued to be "in process." Nurses continued to receive training on how to develop health care plans, and the HMPs were revised to include a place for the direct care staff members' signatures, indicating that they were trained on the plan. The facility's self-assessment for this provision item indicated that, as of July 2012, reviews of data collected from the Care Plan Committee were discontinued due to staff shortages. Thus, the facility concluded that they were not in compliance with this provision item because 100% of the HMPs reviewed by the committee were returned to the nurses for revisions, apparently because they failed to meet basic standards of practice. The monitoring team's review of 21 individuals' records revealed that 95% failed to have specific, individualized nursing interventions developed to address all of their health care needs, including their needs associated with their health risks. As a result, a rating of noncompliance was given to this provision item. Some general comments regarding the 21 sample individuals' care plans are below. Of note, all of the findings were consistent with the findings from prior reviews. • Generic, stock, mini-plans with various dates and time frames, some of which were reviewed at least quarterly, many of which were not, continued to be the	

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		pattern of health care planning at SGSSLC. • Neither of the two individuals with draft IHCPs had planned interventions developed to meet their health needs and risks. • Almost identical HMPs were used to address health problems regardless of the individual's co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem. • Nineteen of the 21 individuals records failed to contain plans that addressed all of the current health needs of the individuals at all times. • Goals and outcomes were not specific, measurable, attainable, relevant, and established in accordance with a time frame for achievement. • Some plans had dates of implementation that preceded their baseline assessment dates. • Despite the changes in individuals' health outcomes, their planned interventions were not consistently revised, as needed, to address their health needs and risks. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #134 was a 77-year-old man with several behavior and physical health problems. Over the past several months, he suffered falls, including one with a serious injury, a stage II decubitus ulcer, and significant, unplanned weight loss, presumably related to meal refusals. Despite Individual #134's changes in his health status, his 5/14/12 health plans to address his falls, alteration in skin integrity, and alteration in thought processes were not revised. In addition, there were no ACPs developed to ensure adequate and appropriate interventions would be developed and consistently implemented related to his weight loss or his head injury with deep laceration of his right ear. • Individual #104 was a 59-year-old man who was diagnosed with many health needs and risks. In addition, over the past several months, Individual #104 was hospitalized for treatment of aspiration pneumonia, and on 10/28/12, he dislocated his right middle finger. As of the review, Individual #104 failed to have HMPs and/or ACPs to address his bilateral lower extremity varicosities and risk of phlebitis, rosacea, hypothyroidism, obesity, enuresis, swallow dysfunction, gait disorder with frequent falls, severe communication deficit, finger dislocation, and status-post aspiration pneumonia. • Individual #314 was a morbidly obese, 42-year-old man who was diagnosed with diabetes, hyperlipidemia, constipation, eczema, osteoarthritis, lactose sensitivity, tobacco abuse, and ceruminosis. Over the past several months, he gained another 14 pounds, his antidiabetes medication was increased, and, on an almost weekly basis, he complained that he was constipated. Nonetheless, as of the review, there were no revisions to his 2/28/12 HMPs to address his diabetes and weight. Of note, on 11/13/12, Individual #314's nurse practitioner wrote	

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		an order to discontinue Individual #314's prune juice secondary to weight gain and elevated hemaglobin A1C. However, the nurse practitioner also ordered that Individual #314's constipation should be monitored and that he should be notified if it occurs. There was no evidence that Individual #314's nurse practitioner was notified of his frequent and consistent complaints of constipation subsequent to his discontinued prune juice, and there was no plan in place to address this problem.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Of the six provisions of section M, M4 has the broadest scope. This provision item clearly ties assessment and reporting protocols to outcomes, and it requires rigorous implementation to achieve substantial compliance. More specifically, this provision item requires that each component of the nursing process is in place and put into practice, such that the health needs of the individuals are met. This means that, when properly implemented, the assessment and reporting protocols should produce results, that is, expected outcomes. Expected outcomes will depend on the individual and his/her situation, and they may include maintaining or attaining health or achieving end of life goals. Regrettably, since the prior review, there continued to be vacancies and turnover in the Nursing Department, such that in August 2012 the Nursing Department declared that they were in a state of critical nursing shortage. Changes occurred in positions with functions and duties that were essential to attaining and maintaining compliance in all provisions of section M. Thus, there were setbacks to achieving improvements and making progress toward substantial compliance. The facility's action plan indicated that, since the prior monitoring review, and with the approval from the state, the Nursing Department "refocused" its plan of improvement and made significant changes to its monitoring, tracking, and recording processes, such that all monitoring was discontinued except for the monitoring of medication administration, which also lapsed for several months. The facility's self-assessment concluded, "This provision is not in substantial compliance because not all training has been completed and compliance in following policies and procedures continues to be an issue." The monitoring team was in agreement with the facility's self-rating of noncompliance. As noted above, since the prior review, the ADOP assumed oversight of the Nursing Department and direct supervision of the CNE. During the monitoring team's interview with the ADOP, she candidly reported that after the prior review, she clearly communicated her expectations for the performance and progress of Nursing Department toward achievement of substantial compliance with the provisions of	Noncompliance

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		section M. One by one, the ADOP met with the facility's nurses, shared her vision for the department, listened to their concerns, and took swift actions to break down barriers, which stood in the way of performance improvement and compliance with the Settlement Agreement and Health Care Guidelines. The changes in the culture of the Nursing Department and the conduct of its nurses, which were immediately noticeable and palpable during all aspects and phases of the review, appeared to be the direct result of the support, guidance, direction, and leadership of the facility's ADOP. Although the ADOP clearly articulated her capacity to enhance and improve the leadership of the Nursing Department, she as clearly stated that she was "not a nurse" and implied that she was relying on the nurses to improve their performance of clinical care and the basic standards of nursing practice. Nurses' knowledge and documentation of the implementation of the state's and facility's assessment and reporting protocols was one area that continued to need improvement. As noted in the prior reviews, and despite reports of nurses training on the protocols, there was no evidence in either the IPNs, comprehensive assessments, or HMPs that the assessment and reporting protocols were consistently and/or correctly used to guide and direct nursing interventions during episodes of acute changes in health, ensure that adequate and appropriate nursing assessments and monitoring of health status changes were completely carried out, and trigger the parameters and time frames for the reporting of signs and symptoms of significant changes in health to the individuals' physician and/or other clinical professionals, as indicated. For multiple individuals, their records revealed the following: • Individuals who suffered temperature elevations failed to have evidence of the implementation of the protocol related to hyperthermia. Thus, there was no evidence of consistent implementation of interventions to prevent dehydration and provide comfort, save for the administration of Tylenol 650 mg and nurses' encouraging increased fluid intake. • At least three individuals who ingested foreign objects failed to have evidence that the pica protocol was followed. • Individuals who suffered episodes of vomiting failed to have evidence of implementation of the protocol developed to address this problem. Thus, some developed fluid and electrolyte imbalance and required emergency medical treatment and/or hospitalization. • Several individuals who suffered head injuries were not assessed or monitored, in accordance with the head injury protocol. This was especially significant for individuals who suffered moderate to serious head injuries, but were mistakenly presumed to have only minor injuries. As a result, they were not closely and completely assessed and monitored, as indicated by the protocol.	

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		• Individuals who were prescribed antibiotics to treat skin infections, urinary tract infections, etc. were not assessed, in accordance with the antibiotic therapy protocol, until resolved. • There was no evidence that individuals who were constipated were consistently assessed within one hour after receiving medication(s) and re-assessed within 24 hours after the medication(s) was given. • Individuals who suffered urinary tract infections failed to have evidence that their nurses looked at their urine, voiding pattern, etc. at least once a shift until resolved. • Across all records reviewed, the SOAP documentation protocol was not consistently implemented. It was clear to the monitoring team that much work needed to be done and many more steps need be taken to ensure that their nurses become knowledgeable of and consistently implement the nursing assessment and protocols. Certainly, additional education and training in this area was needed. Three months prior to the review, one of the unit nurse managers became the facility's new Nurse Educator. She reported that, since she assumed the position, she was working on pulling together the facility's nurses' competency training records. A review of these data revealed low percentages of nurses' completion of requirements for annual competency-based training. However, the Nurse Educator explained that these data may be artificially low because she had not been ale to locate proper documentation of the facility's nurses' receipt of required training. This was a serious problem because it demonstrated the facility's continued failure to ensure compliance with the state's requirements for documenting and maintaining accurate and complete evidence that nurses actually received the orientation and training that they were supposed to receive, and that the facility's nurses were truly evaluated and deemed competent to carry out their duties prior to their assignments to individuals, units and/or the infirmary. In addition, the Nurse Educator reported that almost half of the facility's RNs had not been afforded the opportunity to attend the state's physical assessment and documentation course, and there was no date set for the training course to occur. Other training initiatives and interventions, such as the state's initiative for nurses to attend a mandatory Mosby's Physical Examination Course, a Preceptor Program for nurses, or a Skills Fair, were planned or in the works. Thus, it remained unclear how nurses' training and competence in mandated areas would, or could, occur in the near future. Since the prior review, the RN Case Manager Supervisor spent the majority of her time covering vacant RN case manager positions and duties. At best, she reported she lent	

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		encouraging words to RN case managers, and, at worst, she candidly reported that she was not afforded opportunities to supervise the RN case managers, conduct one-on-one training sessions with the RN case managers, or perform remedial training with nurses who needed additional training and support in specific nursing duties, such as assessment and development of nursing care plans. According to the RN Case Manager Supervisor, when, and if, there were adequate nursing staff members in place, "the education piece that was set up to train RN case managers prior to assigning them units and individuals and to provide ongoing education to improve their performance of their job duties would be very beneficial." With the facility's implementation of the IRRFs and IHCPs, it was unclear how RN case managers would effectively implement these new processes without the RN Case Manager Supervisor's guidance, direction, and oversight of this important aspect of nursing care. Indeed, the RN Case Manager Supervisor plays a significant role and has tremendous responsibility to help facilitate the RN case managers' transition from the old to the new ways of conceptualizing, completing, and implementing individuals' health care plans. Since the prior review, a new Program Compliance Nurse recently joined the Nursing Department. During the monitoring team's interview with the Program Compliance Nurse, she reported on her role in conducting monthly reviews of a number of clinically significant areas, such as intake and output monitoring, infection control, pain assessment, medication administration, etc. For example, the monthly reports of analysis of nurses' performance and compliance with policies, procedures, and protocols referenced brief, yet informative, interpretations of the data, such as the identified areas of noncompliance, as well as recommendations for corrective actions. The Program Compliance Nurse also played a pivotal part in moving the Enteral Performance Improvement Team (PIT) forward toward achieving the goals and objectives of the PIT. For example, the Program Compliance Nurse immersed herself in the project, reviewed all of the data that were captured by the individuals' enteral feeding records, and met with the CNE on weekly basis to review the status of the PIT's progress. As a result, for the first time in over a year, the monitoring team's attendance at the Enteral PIT meeting and review of their reports revealed that there was an average of 95% sustained compliance with ensuring that individuals' enteral feeding records were consistent with and accurately reflected implementation of their physicians' orders for enteral intake from August 2012 through November 2012. Thus, as of the review, the Nursing Department was preparing to present these data to the Quality Improvement Council for their review and approval.	

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		During the prior review it was noted that the Quality Assurance Nurse played a much smaller and less visible role in the Nursing Department's oversight, monitoring, and improvement of nursing care. However, since that time, there was evidence that on several occasions, most notably in July 2012 and September 2012, the QA Nurse forthrightly laid out ways in which the Nursing Department could conceivably prioritize areas of concern, helped them develop processes to examine and meaningfully address their concerns, and implored them to use a model that works, such as the "teach, train, model, and monitor" strategy. During the monitoring team's interview with the QA Nurse, she reported that the Nursing Department was in transition, and that she planned to apply what she had learned during the development and improvement of section H to section M. This was a plan that was yet to be implemented. According to the November 201212 QA Benchmark Meeting and report for section M, there were several possible monitoring endeavors put forward by the Nursing Department for future implementation. For example, the meeting minutes indicated that the CNE stated, "infection control processes may be monitored in future," "urgent care/post hospitalization may be an option for possible inter-rater data," "pain scales are going to be identified for each individual in the future," and "later" additional tools to do more thorough reviews of conditions such as seizures, respiratory issues, pain, etc. will be identified. Although any one, or more, of these areas was ripe for the benefits of monitoring and implementation of corrective actions based upon the results of the monitoring, there continued to be concern that absent a thoughtful, strategic plan by the Nursing Department for their Timeline for Rolling out Monitoring Protocols, their implementation of monitoring protocols may be no more likely to produce positive results and compliance than they were six months to a year ago. It was also a concern for the monitoring team to find that there was no evidence of follow-up to the November 2012 QA Benchmark Meeting minutes reference to a request that was made for data summaries from the Nursing Department that included evidence of follow-up to the recommendations made during the QI Death Reviews for Nursing. Of note, the most recent QA Death Reviews for Nursing, which were submitted to the monitoring team for review, continued to note problems in completing adequate documentation, conducting nursing assessments, developing health management and acute care plans, reviewing health risks, and implementing interventions to address individuals' health problems.	

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M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	At the time of the monitoring review, SGSSLC had completed almost two years of its implementation of the state-approved health risk assessment rating tool and assessment of risk as part of the ISP process. However, throughout this time, there were changes in the forms and format of the processes, which set back some of the facility's implementation strategies. According to the facility's action plan, since the prior review, three action steps were completed, that is, a system was developed to examine nurses' compliance with reviewing and reporting on the Aspiration Trigger Data Sheets, 100% of the Aspiration Trigger Data Sheets were reviewed, and nursing administration was continuing to monitor assigned ISPs to ensure that the proper process was followed. Two action steps were in process, that is the RN case managers were training direct care staff members on their caseload regarding their role in monitoring individuals' triggers of aspiration and a spreadsheet to track corrective actions taken in response to improper review and reporting of the Aspiration Trigger Data Sheets was created. One additional step, which was planned, but not started, was that the Infection Control Nurse would pursue his/her certification in infection prevention and control. According to the facility's self-assessment, "Based on the findings from this self-assessment, this provision is not in substantial compliance because the tools have not been created at this time, therefore, the goals for this provision have not met the measure of success." As noted in the prior report and consistent with the facility's self-assessment, the monitoring team agreed with the facility's rating, but based the conclusion on the facility's continued serious problems with health risk ratings, which were not consistently based upon current, accurate, relevant health data and not consistently revised when significant changes in individuals' health status and needs occurred. One of the most direct ways that the Nursing Department would improve its performance and compliance with the risk assessment and planning processes would be through nurses' implementation of the integrated risk rating assessment process, documentation of individuals' indicators of risk, attendance and participation in the IDT and ISP processes, and development of a complete, accurate integrated health care plan. According to the facility's report, Individual #48's and Individual #127's teams were trained in the revised risk assessment and integrated health care planning process and, during the onsite review, planned to demonstrate the implementation of these processes as part of the course of the individuals' annual ISP preparation and development. Thus, the monitoring team reviewed both individuals' records and attended Individual #127's annual ISP meeting.	Noncompliance

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		The QDDP who chaired the meetings was very organized, well prepared, and knowledgeable of all aspects of Individual #127's life. Although the ISP meeting lasted far too long (i.e., almost five hours), if it were not for the perseverance of the QDDP and her willingness to work through the team's apparent difficulties evaluating and ascertaining the individual's health needs and risks, the meeting would have adjourned without even an outline of a plan. Although all attendees participated in the discussion at one time or another, due to the lengthy time spent in the meeting, team members went in and out of the meeting, some several different times. Thus, portions of the discussion were repeated, reexamined, reanalyzed, and so forth. This left little time and patience for one of the most difficult and challenging parts of the process – articulating adequate planned interventions to achieve the individual's desired outcomes, in accordance with a specified time frame. Thus, it was not surprising that the review of Individual #127's draft IHCP failed to reveal any planned interventions to address his health needs and risks. It was unclear how the RN case manager, who was absent for most of the discussion of the individual's health risks, would develop the plan apart from the input of the IDT members. All 21 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and over three-fourths of the individuals reviewed were referred to as having one or more "high" health risks. All of the 21 sample individuals whose records were reviewed were also reviewed by their IDTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. As noted in the prior report and consistent with the facility's self-assessment, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred. Indeed, at least seven of the 21 sample individuals' records reviewed failed to show evidence of team meetings held in response to significant changes in the individuals' health problems, needs, and risks. Examples included the following: • Individual #218 was a 65-year-old woman with many health needs and risks, including osteopenia, osteoarthritis, and bilateral cataracts. On 9/1/12, Individual #218 fell in the shower and suffered a closed head injury, on 9/12/12, she fell and suffered a scalp contusion, fractured collar bone, and separation of her acromioclavicular joint, and on 10/24/12, she fell and suffered a laceration to her face. A review of her record revealed that despite these falls and serious injuries, her 10/25/11 IRRF was not revised and continued to indicate that she was at low risk of falls and fractures. • Over the past several months, Individual #134 fell and suffered a deep laceration to his right ear, he lost 20 pounds in five months, and he developed a pressure sore. Notwithstanding his health needs and risks, his record contained a	

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		3/18/11 IRRF that had not been revised in over a year and continued to rate his risks of falls, weight loss, and alteration in skin integrity as "low." • Individual #243's 2/18/12 annual physical examination and medical summary indicated that she was "Somnolent, drooling, and nonverbal. Heavily sedated. Sleeps almost constantly, no interest in activities, peers or food. Staggers when she walks [and her] requirement for medications is so strong that she needs a heavy level of sedation to avoid injury." In addition, during the six-month period of 2/18/12 – 8/4/12, Individual #243 lost almost 20% of her body weight. Despite Individual #243's apparent health needs and risks, her 2/10/12 IRRF was not reviewed or revised and referenced her risks related to medication side effects, behavior challenges, and weight as "medium" and absent adequate rationales to support the ratings.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the prior review, the facility's action plan indicated that several steps toward compliance with this provision item were completed, several steps were in process, and some steps were not started. For example, over the past six months, the Nurse Educator and Infection Control Nurse provided training to all nurses in basic medication administration practices and infection control procedures that should be observed during medication administration. In addition, the Nursing Department implemented the use of a new medication variance and medication excess/shortage forms. Also, since the prior review, the Nursing Department continued to use a spreadsheet to help them track and analyze variances in medications and identify areas in need of improvement and/or development of corrective action plans. During the monitoring review, the monitoring team attended the Medication Variance Performance Enhancement Team's meeting. According to the NOO, since September 2012, when she started working on the units as part of nursing leadership's participation in covering vacancies, she identified a pattern of problems with blank entries on the individuals' Medication Administration Records (MARs). For example, the NOO reported that in September 2012, there were 416 blank entries and in October 2012 there were 323 blank entries identified on the individuals' MARs. This was a serious problem because it was unclear whether or not the blanks were indicative of medication administration errors and/or documentation errors. Thus, the NOO conducted a look-behind analysis and concluded that in September 2012, 17 of the 417 blank entries were medication administration errors, and the rest were medication documentation errors. It was unclear whether or not the NOO conducted a similar analysis of the October 2012 blank entries. According to the rest of the medication variance data presented at the meeting, in October 2012, there were 11 errors related to omissions, 416 errors related to wrong administration technique, six errors related to	Noncompliance

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		wrong dosage forms, and one error related to wrong drug preparation. Of note, these problems and errors occurred against a backdrop of the facility's October 2012 report that "Medication administration monitoring scores have drastically improved since the last monitor's visit." Notwithstanding the facility's report of drastic improvement, the self-assessment concluded, "This provision item was not in substantial compliance because nurses were not correctly documenting medication administration per facility policy." The monitoring team's review revealed that much work still needed to be done to ensure that the nursing practices associated with medication administration and accountability were carried out in accordance with generally accepted professional standards of practice and the Health Care Guidelines. Thus, consistent with the facility's self-assessment, this provision item was rated as being in noncompliance. Observations of medication administration, oral and enteral, were conducted on selected units. During two of the five observations, there were numerous violations of accepted professional standards of nursing practice and violations of basic infection control practices and procedures. For example, during one or more of the four medication observations, nurses failed to use the individuals' MARs during medication administration, properly sign and verify that medications were administered as ordered, provide individuals with privacy, sanitize and/or wash their hands between their contacts with individuals and/or soiled materials, and ensure that all crushed, dissolved, and otherwise altered medications were completely given and not left in discarded medication and drinking cups and/or adhering to enteral feeding equipment. Also, as noted during all prior reviews, on 516W, liquid- and pill-form medications were pre-poured together into unlabeled medication cups, set on a shelf in the medication room, and administered by the nurse well over an hour later. Since the prior review, there was no evidence of follow-up by the nurses with the pharmacist to ascertain that there were no problems with pre-pouring and mixing 10 or more crushed medications along with Mylanta, guaifenesin, and liquid multivitamin altogether in a plastic cup and allowing the mixture to sit for over an hour before administration. A number of the 21 individuals reviewed had a SAM (self-administration of medication) assessment and designation filed in their record. During the observations of medication administration, the nurses uniformly treated individuals with respect and dignity during medication administration, but, with the exception of two observations, observations failed to reveal that reasonable attempts were made to implement the individuals' SAM	

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		program. The review of 21 individuals' MARs for the period of 10/1/12-11/30/12 revealed no improvement in performance from the prior review, and actual decline. Twenty of the 21 individuals reviewed had omissions and/or discrepancies in their MARs. These omissions and discrepancies included missing entries for psychotropic, anticonvulsant, diabetic, gastrointestinal, bowel, antibiotic medication(s), vitamins/supplements, and/or oral, wound, and/or skin treatments during the one-month period.	

Recommendations:

1. Continue to provide the Nursing Department with assistance from the facility's senior management to continue guiding, directing, and supporting the CNE's strategic plan to effectively utilize the nurses in leadership and management positions to achieve substantial compliance with the provisions of section M (M1-M6).

2. Develop strategies to recruit and retain nurses, such as sign-on bonuses, recognition and reward for excellent performance, etc. (M1-M6).

3. The CNE should consider developing ways in which all nurses in leadership positions show evidence of weekly progress toward achieving goals/steps toward compliance with the provisions of section M (M1-M6).

4. Re-establish infection prevention and control and skin integrity programs at the facility, in accordance with generally accepted standards of practice (M1-M6).

5. Implement procedures to monitor the care and treatment of individuals who are hospitalized and/or transferred to alternate levels of care on weekends and holidays (M1).

6. Develop ways to help nurses understand how they should be using the standardized nursing assessment and reporting protocols during their daily routines (M1–M6).

7. Continue to work on ensuring that nurses consistently document health care problems and changes in health status, adequately intervene, notify the physician(s) in a timely manner, and appropriately record follow-up to problems once identified (M1, M4).

8. Ensure that nursing assessments are complete and comprehensive and conducted upon significant change in individuals' health status and risks (M1, M2, M5).

9. The facility should provide more training to its nurses in relation to the conduct and completion of the IRRFs and IHCPs (M3, M5).

10. The QA and Nursing Departments should work together to address the repeated findings and recommendations in the QI Death Reviews for Nursing (M1-M6).

11. Re-examine the process of monitoring medication administration to ensure that results are valid and reliable measures of the process (M6).

12. Consider developing ways in which the Nurse Compliance Coordinator's monitoring activities can affect real change(s) in the delivery of nursing care (M1-M6).

13. Review and revise the self-assessment process to ensure that the activities engaged in to conduct the self-assessment completely reflect and are truly relevant to the provision items (M1-M6).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, o SGSSLC Self-Assessment for Section N o SGSSLC Action Plan Provision N o SGSSLC Provision Action Information o SGSSLC Organizational Charts o SGSSLC Pharmacists Prospective Review Of Medication Orders, 11/17/11 o SGSSLC "PRN" Medication Pharmacy Review, 11/17/11 o SGSSLC Quarterly Drug Regimen Review, 11/17/11 o DISCUS - Monitoring of Medication Side Effects and Tardive Dyskinesia, 9/22/11 o MOSES – Monitoring of Side Effects 4/26/11 o SGSSLC Suspected Adverse Drug Reactions 1/27/11, Rev 11/17/11 o SGSSLC Pharmacy and Therapeutics Committee, 4/19/12 o SGSSLC Drug Utilization Evaluation 11/17/11 o SGSSLC Lab Matrix, 9/15/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 3/21/12, 7/25/12 o PET Medication Error/Medication Variance Review Committee Meeting Notes, 2012 o Polypharmacy Committee Meeting Minutes, 2012 o Review of Physicians' Orders and Clinical Interventions, April 2012 – October 2012 o Adverse Drug Reactions Reports 2012 o SGSSLC Medication Variances, May 2012 – October 2012 o Physician Orders, June, August, October, 2012, Days 1-7 o Drug Utilization Calendar, 2012 o Drug Utilization Evaluations • Phenytoin • Lithium o Quarterly Drug Regimen Review Schedule, 2011-2012 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #59, Individual #196, Individual #104, Individual #391, Individual #193, Individual #153, Individual #389, Individual #24, Individual #178, Individual #52, Individual #349, Individual #169, Individual #337, Individual #265, Individual #16, Individual #290, Individual #151, Individual #291, Individual #380, Individual #153, Individual #80, Individual #231, Individual #235, Individual #43, Individual #298, Individual #68, Individual #182, Individual #14, Individual #200, Individual #338, Individual #57, Individual #398, Individual #76, Individual #166

	o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #150, Individual #22, Individual #165, Individual #126, Individual #26, Individual #29, Individual #127, Individual #169, Individual #283, Individual #38, Individual #379, Individual #193, Individual #331, Individual #253, Individual #162, Individual #170, Individual #288, Individual #18, Individual #53, Individual #328, Individual #294, Individual #251 Individual #163, Individual #151 Individual #78, Individual #291, Individual #128, Individual #278, Individual #50, Individual #132, Individual #90, Individual #196, Individual #244 <u>Interviews and Meetings Held</u>: o Donald Conoly, RPh, Pharmacy Director o Philip Rolland, PharmD, MHA, Clinical Pharmacist o Ronnie Marecek, RPh, Staff Pharmacist o Joel Bessman, MD, Acting Medical Director o Scott Lindsey, APRN, FNP, Medical Administrative Director o John Burnside, MD, Primary Care Physician o Albert Fierro, RN, Medical Compliance Nurse o William Bazzell, MD, Psychiatrist o Angela Gardner, RN, Chief Nurse Executive o Lisa Owens, RN, Quality Enhancement Nurse o Charles Njemanze, Facility Director <u>Observations Conducted</u>: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Performance Evaluation Team Meeting o Administrative IDT Meeting o Polypharmacy Committee Meeting o Pharmacy Department
	Facility Self-Assessment: SGSSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For some provision items, the pharmacy director listed activities engaged in to conduct the self-assessment. These activities were usually a review of data. The results of the activities were presented followed by a self-rating. Generally, the facility's self-assessment did not appear to be very helpful in helping to establish an accurate assessment of the facility's status. This was in part due to a lack of reliable and valid data. A good self-assessment will require input of good data in order to yield good results. For the most part, the metrics used through the self-assessment were not good instruments to measure progress for the provision items. In many cases, the results were not reliable due to accuracy or presentation.

	For provision N1, a series of charts were presented providing numbers of clinical interventions, drug interactions, and lab monitoring. Explanations regarding the clinical relevance of these numbers were not provided. In assessing this provision item, the pharmacy director should conduct activities similar to those of the monitoring team. For example, the pharmacy director should pull a sample of pharmacy orders, as the monitoring team does, review them for completeness and ensure that problematic orders are entered into the clinical interventions log. The clinical interventions log should be reviewed to determine if entries are complete and followed through to closure. Data for drug interactions should extend beyond listing numbers. There should be documentation that the appropriate notification and closure occurred for drug interactions. For Provision N2, the self-assessment presented the number of QDRRs reviewed to ensure they were completed and contained all required elements. The numbers presented did not reflect what information was truly relevant to the provision item. The measurable items were actually the number of QDRRs completed in a timely manner and the number that contained the required elements. The monitoring team reviews timelines and content. The data presented for Provision item N3, was simply the number of events that occurred. There were no explanations regarding the clinical relevance of the numbers or how they helped to determine the self-rating. The facility submitted two blank charts for provision N4. The significance of that entry was unknown. For provision N5, the data for N2 were simply repeated – the number of QDRRs completed. For this section, the facility should review the number of MOSES and DISCUS forms that are completed in a timely manner. Additional information could include some assessment of how the information is being used by clinicians. The remainder of the self-assessment continued the pattern of providing numbers or data that did not translate into useful information. In moving forward, the pharmacy director and clinical pharmacist should read the content of this report and recommendations. Future self-assessments should review those items that are reviewed by the monitor as well as additional relevant items. The facility rated itself in noncompliance with all provision items, although the text of N7 cited substantial compliance. The monitoring team found the facility to be in noncompliance with all eight provision items.

	Summary of Monitor's Assessment: At the time of the onsite visit, the pharmacy department was staffed with a pharmacy director, full time clinical pharmacist, full time pharmacist, and three pharmacy technicians. There was no demonstrable progress in this area. Throughout the week of the compliance review, the monitoring team had the opportunity to have many discussions with the pharmacy department staff, facility director, and medical leadership regarding the provision of pharmacy services. The numerous meetings conducted during the week provided valuable insight into the practices of the facility. The information derived from a wide variety of activities indicated that many of the problems noted during the June 2012 review had not only persisted, but in many instances had worsened. Few, if any, areas showed slight improvement. There was relatively little documentation of communication between the pharmacists and providers given the number of medications prescribed and dispensed. The pharmacy department continued the practice of not reporting prescribing errors even though this was required by state policy and the requirement was highlighted in the June 2012 report. The facility implemented the Intelligent Alerts two weeks before the compliance review and there was no real explanation for why SGSSLC's implementation lagged behind that of other SSLCs. Completion of QDRRs remained a challenge for the facility. Data submitted by the facility indicated that 70% of individuals did not have current QDRRs as of 12/7/12. Only one of 10 records in the record sample had a current QDRR. These were not new findings and the facility appeared to make little progress in determining how to move forward and correct this very significant problem. Monitoring for metabolic syndrome via the QDRR lacked the necessary thoroughness and tracking the frequency was difficult. Polypharmacy continued to be problematic for the facility. The initial challenge was correctly defining and counting polypharmacy. There was essentially no ADR reporting since the last compliance review. Training was reported to be ongoing, but the monitoring team found the content of the training to be less than adequate. Much of the training for health care professionals was self-directed and apparently ineffective because no health care professionals outside of the pharmacy reported ADRs. Follow-up of ADR issues was also not consistent with policy. DUEs were completed, but were not presented to the Pharmacy and Therapeutics Committee in a timely manner resulting in a delay of corrective actions. The facility reported medication variances, but continued to struggle with having a comprehensive program in which all disciplines worked cooperatively to improve the system. Prescribing errors were not reported and the inability to provide information related to pharmacy reconciliation and returned medications called into question the facility's ability to gather data at every step of the medication use system.

	The medication use system was riddled with inherent complexities. Process mapping cannot capture the effects of staffing or the unanticipated nature of healthcare delivery. A safe and effective medication use system requires teamwork. Systems thinking demands that health care professionals move out of their silos, work as teams, and hold each other accountable to the team. Observations suggest that the facility will continue to struggle to move forward in this area. The pharmacy staff was not receptive to feedback provided by the monitoring team. Furthermore, there was a reluctance to accept accountability for problems. During meetings and discussions, the pharmacy staff attributed deficiencies to other disciplines, a lack of guidance from state office, the facility director, and even guidance from other SSLCs. There was also a lack of transparency in how the department presented information. For example, in presenting data on the number of QDRRs completed, there was no indication given that the facility had not completed QDRRs over an extended period. Therefore, it was possible that facility management was unaware of the magnitude of the deficiencies related to QDRR completion. This lack of transparency was quite evident in the P&T Committee meeting in which polypharmacy data, which had been determined to be inaccurate, were presented to the committee with no statement regarding the earlier findings. Moving forward will require major changes in the culture in the pharmacy department as well as substantial improvement in the work product.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The pharmacy director reported that prospective reviews were completed for all new orders through the WORx software program. The program checked the standard parameters, including therapeutic duplication, drug interactions, and allergies. The policy Prospective Review of Medication Orders was approved on 11/17/11 and was implemented the following month. The goal of the prospective review was to assure the appropriateness, safety, and effectiveness of the medications used. The policy outlined the steps used to achieve this goal: 1. The pharmacist or technician entered information into the WORx software. Medication was dispensed only after the order was entered. 2. The pharmacist reviewed all orders entered by the technician. 3. The pharmacist, in conjunction with WORx, reviewed the orders for allergies, indications, contraindications, etc. 4. Any questions regarding the orders were resolved with the prescriber and a written notation of these discussions and resolution was made in the Pharmacist Review of Physician Orders and Clinical Interventions Worksheet. 5. The pharmacist contacted the prescriber for Level I and Level II drug interactions. The prescriber was provided a written monograph for Level III interactions. The monitoring team requested copies of all clinical interventions documented since the last onsite review. A document entitled " Pharmacist Review of Physician's Orders and	Noncompliance

Clinical Interventions" documenting 57 interventions from April 2012 through October 2012 was submitted. This log was intended to include the date of the order, individual case number, medications involved, reviewing pharmacist, problems with order, physician, physician's response, and resolution. The pharmacy also recently implemented a telephone communication log to assist in documenting communication between providers and the pharmacists. The number of interventions is summarized in the table below.

Physician Order Review and Clinical Interventions 2012							
	Apr	May	June	July	Aug	Sep	Oct
No. of Interventions	12	3	7	13	13	22	11

Overall, a relatively small number of interventions were documented. The majority of documentation was related to the lack of medication indications. There were also several interventions related to medications prescribed with documented allergies. Several of the orders involving allergies should have been considered medication variances. The log provided did not indicate which pharmacist was involved in the communication. It also was not always clear who was contacted for clarification. Several incidents had no resolution documented, lacked the prescriber involved, and some lacked the individual's identifying data.

As a separate document, the Single Patient Intervention report recorded numerous Level I and Level II potential drug interactions. The management and communication of potential drug interactions was not documented in the interventions log even though facility policy required that pharmacists contact the prescriber for Level I and Level II drug interactions and provide a written monograph for Level III interactions. The SPI provided no evidence of communication or outcomes. There were no Level III interactions recorded.

The monitoring team requested copies of orders received in the pharmacy for the first seven days of June, August, and October 2012. The pharmacy's annotated copies were requested. The October 2012 submission was incomplete and it was noticed that the orders submitted contained little documentation by the pharmacy. It was not clear that the orders submitted were those that included the clarification notes and other pharmacy documentation. The monitoring team could not identify some orders related to the log entry that should have been included with the document submission. The orders were matched by date and drug since the log did not include any identifying data that the monitoring team could use. For those orders that could be matched to the log, the documentation of clarification of the orders was not adequate in either document. As already mentioned, neither the pharmacist nor person contacted was identified in the documents submitted.

		Generally, the problems with physician order writing noted in the last compliance review appeared to decrease over time. There were several examples of vague and unclear orders. The problem with unsigned verbal orders persisted, however, this was seen less in the August 2012 sample and the October 2012 sample was largely incomplete. Examples of problematic orders included: • Individual #203, 6/2/12, was prescribed Macrobid, but no diagnosis was provided. This individual was also allergic to Macrodantin and received the drug. This incident was not reported as a medication error. • Individual #18, 6/6/12, had a vague order written to change back to Keppra 500 mg po. Finally, this provision item required "upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." Approximately two weeks prior to the compliance review, the facility implemented the Intelligent Alerts, which required laboratory monitoring for seven drugs: carbamazepine, dilantin, valproic acid, phenobarbital, lithium, levothyroxine, and warfarin. This process also occurred for Clozaril. The facility had not developed a list of additional drugs for monitoring. The pharmacy director indicated that there was no specific directive from state office with regards to a timeframe for implementation of the Intelligent Alerts. The November 2012 implementation appeared to be delayed based on rollout information provided by state office. The training was provided in late August 2012. With only two weeks of use, the pharmacy director had not run any reports related to ensuring that monitoring was occurring as required nor was he familiar with this recommendation from state office. Achieving substantial compliance will require that the department increase the quantity of documentation, but more importantly improve the quality of the documentation. Further guidance is provided in the recommendations section. This provision remained in noncompliance.	

N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The Drug Regimen Review policy was approved on 11/17/11. It provided the framework for evaluating an individual's medication regimen retrospectively. According to policy, QDRRs were completed every 90 days and included a pharmacy review of allergies, contraindications, dose, route, duplication of therapy, interactions, and proper utilization. Following completion by the pharmacist, the Quarterly Drug Regimen Review, which included the worksheets, was forwarded to the primary providers and psychiatrists for review. In order to expedite this process, the QDRRs and active records were delivered to the clinical services meetings for physician review. The total allocated turn around time from pharmacy review to physician review was 14 days. State office provided further guidance and required that a QDRR schedule be generated for the facility that assigned four due dates (every three months) for completion of QDRRs. Per state guidelines "the QDRR may be conducted up to seven days prior to the end of the review period and will be considered delinquent if completed 14 calendar days from the end date of the review period. All subsequent review periods will be set in three month increments from the initial review period…" During the compliance review, the clinical pharmacist reported in the Pharmacy and Therapeutics Committee meeting that QDRRs were not completed for several weeks due to heavy workload. In fact, the quarterly pharmacy report documented that no QDRRs were completed during the month of October 2012. The facility's QDRR schedule was incomplete and, therefore, the monitoring team requested the dates of the last two QDRRs for every individual living at the facility. Based on this document, it appeared that 155 of 221 (70%) individuals did not have current QDRRs at the time the document was submitted on 12/7/12. The most recent QDRRs were completed in September 2012. The QDRR sample included several documents that were actually blank, but signed by providers. These QDRRs included a statement that the records were not available. Given that these QDRRs were credited as completed, completion rates were likely lower than 30%. Turnaround times for physician review for the QDRRs in the sample were acceptable. Poor compliance with timeline requirements and missing QDRRs were highlighted in the June 2012 report with specific recommendations made to conduct a through assessment of the causes. It was not clear if this occurred, however, it was more than apparent that the facility had not adequately addressed the problem and did not have a plan to ensure that the fundamental requirement of completing QDRRs occurred. A sample of 34 QDRRs was reviewed. The format of the QDRRs was revised. The report included the worksheet, which had been revised to become more readable. The worksheet criteria differed from the lab matrix leaving the pharmacist to apply the matrix as clinically applicable. An additional section was added to the worksheet for monitoring metabolic risks. Another section was added for the PCP to write orders for recommendations that were accepted, but that component was not implemented. Apart from the problem of failure to complete QDRRs, there were several other problems	Noncompliance

		observed with the QDRRs reviewed: • Incomplete lab values continued to be presented. For example, for Individual #349, an MCV of 99.8 H was documented, but no hemoglobin or hematocrit was documented. The clinical relevance of an elevated MCV was not clear without knowing the associated Hb and Hct. Similar examples were seen in numerous evaluations in the sample reviewed. • A single set of lab values was presented resulting in little opportunity to detect trends. The monitoring team could not determine if the frequency of monitoring was appropriate with limited data. • Recommendations were often vague. One recommendation for individual #291 was to consider decreasing polypharmacy, but no specific recommendations were made. The worksheet component of the report contained a comment that the quetiapine dose exceeded the recommended maximum dosage, but there was no recommendation related to this. • The data were often outdated. For example, the weights listed with the current labs were frequently from 2011 or 2010. The vital signs documented were often noted to be from six or seven months before the date of the review. • The comments section of the worksheet included items that should have been formal recommendations. • Abnormal lab values were frequently not addressed. The following are a few examples of the problems discussed above: • Individual #182, 9/26/12 received FazaClo and lithium. The pharmacist noted that there was no CMP in the record and a recommendation was made to obtain one. The comments of the work sheet documented that a UA was done on 5/17/12, but no results were provided. The weight reported for this individual was dated 12/10/11. This individual lacked the appropriate monitoring for both antipsychotic medications. • Individual #14, 9/26/12: This individual was treated for hypertension. The lab matrix required an annual EKG. The last EKG was obtained in April 2011. There were no blood pressures or heart rates recorded in the worksheet. The pharmacist made a recommendation to obtain the annual EKG. • Individual #338, 9/26/12, did not have monitoring of lipid status required for use of new generation antipsychotic. The pharmacist made the recommendation to obtain the lab. • Individual #76, 9/26/12, received FazaClo, quetiapine, and divalproex. The weight reported was dated 12/8/11 and was outside of the range at 165 lbs. with a BMI 26.6. The UA was reported as done on 9/12/12, but no results were documented. Multiple iron studies were listed, but the CBC was reported as WNL. There was no glucose or HbA1c documented. The clinical pharmacist recommended obtaining lipids and a prolactin. While a CMP was obtained, the	

		results of the glucose were not documented. • Individual #200, 9/26/12: This individual was treated for hypertension and hyperlipidemia in addition to receiving a new generation antipsychotic. The individual's weight on 9/7/11 was 250 lbs. (122-150). There was no follow-up weight noted. The last blood pressure on the worksheet was June 2012. There was no discussion, comment, or recommendation related to the risk of continued use of an NGA for this individual. The only recommendation was to complete the MOSES and DISCUS evaluations. • Individual #43, 9/10/12, received lithium, olanzapine, and levetiracetam. There was no documentation of a urinalysis for lithium use. The reported weight, dated 2/15/12, was 136 lbs. (160-202), BMI 17.9. There was no follow-up weight. A recommendation was made to obtain an EKG due to hypertension and the use of antipsychotic medications. There was no medication prescribed for hypertension. Overall, this individual lacked several aspects of appropriate laboratory monitoring Notwithstanding the aforementioned deficiencies, the QDRRs did provide some good information and detected the lack of monitoring for several individuals. The current worksheet format, however, did not lend itself to the use of the facility's lab matrix because the worksheet and lab matrix criteria differed making it difficult to ensure that every parameter was captured. If the facility must use the worksheet as part of the report, consideration should be given to revising the worksheet and including the lab matrix criteria in order to provide consistency in the reviews. The monitoring team offers the following recommendations: • The QDRR Report should comment on every medication/class of medication that is included in the lab matrix. The exact value should be provided with the date as well as an indication of the range of values. • The pharmacist should clearly state the recommendations. If the provider must take an action to remediate a finding, a recommendation should be given. • Providers should document a rationale in the IPN for recommendations that are not accepted. • Identification of polypharmacy should result in a brief statement regarding the use of multiple drugs. The statement should note, when appropriate, any recommendations for drug reduction. • For individuals who receive medications associated with metabolic and endocrine side effects, the report should provide a concise summary of the monitoring, the risk, and any recommendations for risk mitigation. The monitoring parameters such as weights should be updated with each evaluation. • QDRR reviews must occur in accordance with state issued guidelines timelines. This provision remained in noncompliance.	

N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications was documented in the QDRRs. For each use, there was a comment related to the indication and effectiveness. The use of stat and emergency medications was also discussed in the daily clinical meeting. The use of PRN meds is discussed further in section J. <u>Polypharmacy</u> The QDRR report form indicated the presence or absence of polypharmacy. In many instances when polypharmacy was noted, the clinical pharmacist inquired about the possibility of reducing the number of medications. There were instances in which the psychiatrists noted that the recommendation was inappropriate, as polypharmacy did not exist. Overall, the fundamental flaw with the management of psychotropic polypharmacy was that the facility counted AEDs used for management of seizure disorder as psychotropic agents. Even more troubling was the rationale explained by the pharmacy staff in the polypharmacy committee meeting. AEDs were counted as psychotropic because they altered cognitive function. The monitoring team strongly cautioned against the use of such reasoning because many agents used to treat hypertension and a host of other illnesses are known to alter cognitive functioning. The result in terms of polypharmacy was that the data collected by the facility were inaccurate. Psychotropic polypharmacy and the Polypharmacy Oversight Committee are addressed in further detail in section J. <u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk was stratified as low, medium, or high. Information was provided when management plans for constipation were implemented and references to MOSES scores were sometimes noted. Overall, attention was given to this issue. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risks through the QDRRs. The worksheets included information, such as weight, BMI, and Hba1c. The monitoring team noted that when these values were very abnormal, the clinical pharmacist did not relate these abnormities to the use of new generation antipsychotics or make any comments about the risk of continued use. QDRRs were identified in which the monitoring parameters were not identified. There were also several QDRRs that required recommendations to obtain the appropriate laboratory monitoring. Overall, the facility will need to demonstrate improvement in appropriate monitoring in this area.	Noncompliance

		This provision remained in noncompliance.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the provider's responses to both prospective and retrospective reviews. The Clinical Interventions log provided information on the prescribers' responses to some issues, but it was not clear who was contacted and several items lacked responses. There was also no documentation provided of responses to the numerous drug interactions that were documented, although no Level III interactions were found. With regards to responses to the recommendations made in the QDRRs, only one of 10 records in the record sample had a current QDRR. For the 25 QDRRs reviewed, 22 included recommendations, one had no recommendations, and two QDRRs were blank. Provider Reponses for recommendations are below: • 20 of 22 (91%) evaluations involved antipsychotic medications • 14 of 20 (70%) evaluations were reviewed by the psychiatrist o 13 of 14 (93%) indicated the recommendations would be reviewed during psychiatry clinic staffing o 1 of 14 (7%) indicated disagreement with the recommendations • 18 of 22 evaluations include medical recommendations o 13 of 18 (72%) evaluations indicated agreement by the primary provider o 4 of 18 (22%) evaluation provided explanations, such as labs in record, by the primary provider o 1 of 18 (6%) evaluations indicated disagreement by the primary provider There was evidence that the primary providers responded to the recommendations of the clinical pharmacist or provided explanations for opting not to accept the recommendations. Evaluating the responses of the psychiatrists was more difficult because a significant percentage (30%) of the evaluations were not reviewed by the psychiatrists. Evaluation was further complicated by the fact that the psychiatrists frequently did not agree or disagree, but stated that the issue would be reviewed during staffing. The clinical pharmacist indicated that new tools had been recently implemented to track the responses of the providers. It will be particularly important to provide follow-up for the psychiatric recommendations to ensure that the reviews occur as indicated and within the timelines established by facility policy. This provision item remained in noncompliance.	Noncompliance

N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. A sample of the most recent MOSES and DISCUS evaluations submitted by the facility in addition to the most recent evaluations included in the active records of the record sample were reviewed. The findings are summarized below: Thirty-five MOSES evaluations were reviewed for timeliness and completion: • 32 of 35 (91%) evaluations were signed and dated by the prescriber • 8 of 35 (23%) evaluations documented the presence of side effects • 32 of 35 (91%) evaluations documented no action necessary • 3 of 35 (9%) evaluations lacked a prescriber conclusion (blank) Thirty-seven DISCUS evaluations were reviewed for timelines and completion: • 35 of 37 (95%) evaluations were signed and dated by the prescriber • 23 of 37 (62%) evaluations indicated the absence of TD • 10 of 37 (27%) evaluations indicated the presence of TD • 1 of 37 (3%) evaluations indicated the presence of probable TD • 3 of 37 (8%) evaluations had no prescriber conclusion (blank) The facility's MOSES and DISCUS policies required completion of the MOSES evaluation every six months and the DISCUS evaluation every three months. The self-evaluation related to this provision item included blank charts prompting the monitoring team to request further information. Data submitted by the nursing department, based on the psychiatry schedule, indicated that over the past eight months, the average compliance with timely completion of the MOSES and DISCUS evaluations was 39% and 42% respectively. Furthermore, for a sample of 24 QDRRs completed in September 2012 and submitted by the pharmacy department, 16 of 24 (66%) included comments indicating that the MOSES, DISCUS, or both evaluations were not current. The psychiatrists were responsible for the final review of both evaluations. During the June 2012 review, it was reported that the MOSES evaluation would be also be reviewed by the primary provider. This was also documented in the March 2012 P&T minutes. All but one of the documents reviewed were signed by the psychiatrist. There appeared to be improvement in the turn around times of physician reviews. During the last compliance review, delays of four to six weeks were noted. For the sample of 72 documents reviewed, 15 of 72 (21%) had timelines of greater than 14 days, but less than 30 days and 4 of 72 (6%) had turn around times that exceeded 30 days. The monitoring team noted that the MOSES form utilized varied. Specifically, the	Noncompliance

		prescriber review section lacked the option to check the presence or absence of side effects on many of the documents submitted. Identification of the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia has great clinical significance. The MOSES and DISCUS evaluations should be completed in a timely manner and the information promptly provided to the physicians for review. The data must be reviewed by the primary providers and psychiatrists and must be provided to consulting neurologists for review. The records should provide evidence that this information was utilized by the facility providers in clinical decision-making. This provision item remained in noncompliance. In order to achieve substantial compliance, the facility must demonstrate that these evaluations are thoroughly completed in a timely manner and are utilized in clinical practice.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow-up remedial action regarding all significant or unexpected adverse drug reactions.	The facility implemented a revised ADR policy in November 2011, which included a probability scale, a severity rating scale, and critical indicators for determining the need for an intense case review. A risk probability number was included as a means of proactively identifying potential problematic ADRs for intense review. The policy also defined the roles of health care and direct care professionals in reporting adverse drug reactions. The clinical pharmacist indicated that all ADR reporting at the facility was done by the pharmacy staff. Two ADRs, reported in August 2012, were the only ADRs recorded since the last compliance review. SGSSLC documented 12 ADRs for the months of April 2012 through September 2012. Opportunities for reporting suspected ADRs are discussed in section N7. Notwithstanding the implementation of an adequate procedure, the facility made minimal progress with the ADR reporting and monitoring system. The clinical pharmacist was confident that adequate training was provided. There were two primary training initiatives. The first was an ADR trigger list that was developed and submitted to the nursing department in April 2012 for self -directed training. This information was also submitted to the medical staff and was provided for dissemination to direct care professionals. The Nurse Educator also planned to use this material during New Employee Orientation. While the monitoring team has recommended the use of a trigger list, the list presents information that may be included as one component of a training program, but should not be considered as "the training." Moreover, the content of the facility's trigger list should be reviewed for accuracy of the content. For example, the final item on the list stated, "Any hospitalization, supportive treatment or significant change in prognosis…. disability or death should be considered a possible ADR." While the monitoring team supports the premise that ADRs associated with death and disability are sentinel events and other events, such as hospitalizations warrant intensive	Noncompliance

		review and possible classification as sentinel events, the corollary statement is not necessarily true. That is, not every hospitalization or change in prognosis warrants consideration as a possible ADR. The second training was a statewide effort entitled "Observing and Reporting Clinical Indicators of Health Status Change." It was included as part of NEO. A copy of the Powerpoint was provided for review. The material included information on signs and symptoms of clinical illness, but it not include information specific to the ADR monitoring and reporting system. Based on the information submitted by the facility, it did not appear that the content of the ADR training was adequate. The facility should reassess the use of the self-directed training. During discussions with the pharmacy staff, the terms training and inservice were used repeatedly. Upon further exploration, it was determined that in many instances the terms were used when documents were emailed to a department head for dissemination to staff who then read the information. The monitoring team recommends that the training department provide some guidance on development of appropriate adult training materials because each discipline must have targeted training and previous training techniques have resulted in little impact on reporting. The problems with the ADR system were not limited to under-reporting. The Pharmacy and Therapeutics Committee minutes, dated 7/25/12, lacked follow-up of previous ADRs other than a statement that the 4/18/12 ADR would be discussed in the daily clinical meeting. The Pharmacy and Therapeutics Committee, was charged with the responsibility of reviewing ADRs, developing corrective action plans relative to ADRs, and ensuring appropriate follow-up. As such, the committee minutes should include the appropriate documentation. This requirement did not prohibit the immediate discussion at the daily clinical meeting. The lack of attention to follow-up of ADRs and other pharmacy issues prompted the monitoring team to inquire about the corrective actions policy presented during the December 2011 review. This policy was reportedly developed to ensure that the Pharmacy and Therapeutics Committee provided oversight to the implementation and follow-up of corrective action plans. The monitoring team reviewed the draft policy during the December 2011 review and provided comments in the monitoring team's report. The clinical pharmacist indicated that the policy was probably not approved. The Pharmacy and Therapeutics Committee policy revised 4/19/12 referred to the development of a Corrective Actions Plan Process Policy and Procedure. The P&T policy included a sample plan as an attachment. It appeared that this corrective action process was not followed as designed.	

		Overall, SGSSLC did not maintain an adequate system for monitoring and reporting ADRs. The number of ADRs documented was relatively low and reporting to the Pharmacy and Therapeutics Committee was delayed due to the infrequent meetings. There was also no documentation of follow-up of corrective actions or the outcomes of cases that were referred for intense case review. Finally, the facility did not implement adequate training to ensure that health care and direct care professionals had adequate knowledge related to monitoring and reporting of ADRs. In order to achieve substantial compliance, the facility will need to take several steps related to the ADR monitoring and reporting system: • There should be increased reporting by the medical staff and other health care professionals. • ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director. All three should be required to sign the ADR reporting form. The form should indicate who initiated it (reporter). • All ADRs should be reported to the Pharmacy and Therapeutics Committee in a timely manner. This committee is charged with reviewing ADR data, analyzing the data for patterns or trends, and developing preventive and corrective actions. The ADR form should reflect the final determination by the P&T Committee and should be signed by the chair. The committee should also receive follow-up on the status of the corrective actions. • Opportunities for educational efforts to train on prevention of ADRs should be identified. The daily clinical meeting provides a good forum for educational activities. • All healthcare professionals and others with extensive contact with the individuals have the ability to recognize and report adverse drug reactions. The facility must ensure that all medical providers, pharmacists, nurses, and direct care professionals receive appropriate discipline-specific training on the recognition of ADRs and the facility's reporting process. • The facility must ensure that there is appropriate follow-up of ADRs and cases that meet the threshold for intense case review. This provision remained in noncompliance.	

N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility's DUE policy required completion of one DUE each quarter based on the calendar set by the Pharmacy and Therapeutics Committee. The facility did not have a schedule for calendar year 2013. Two DUEs were completed since the last compliance review. Those evaluations are summarized below. The objectives of both DUEs were to (1) evaluate the appropriateness of the indications and monitoring, (2) assess for the presence of adverse drug reactions, and (3) make recommendations regarding appropriate drug use, monitoring and expected clinical outcomes. **Phenytoin DUE** The phenytoin DUE was completed in June 2012 and presented at the July 2012 Pharmacy and Therapeutics Committee meeting. <u>Methods</u> Seven individuals were receiving phenytoin. Individuals were selected for inclusion in the study if there had been a QDRR conducted on them during the last quarter of 2011 or the first quarter of 2012 using the new QDRR. A total of 6 individuals met this criteria and were selected for review. <u>Results</u> The following results were reported: • 6 of 6 (100%) individuals had appropriate lab monitoring (CMP, CBC, LFT) • 6 of 6 (100%) individuals had appropriate completion of the MOSES evaluations • 5 of 6 (83%) individuals had appropriate therapeutic drug monitoring • 5 of 6 (83%) individuals did not have folic acid levels monitored • 5 of 6 (83%)individuals had drug levels outside of therapeutic range • 4 of 6 (67%) individuals had either neurologic or psychiatric side effects • 3 of 6 (50%) individuals had Vitamin D levels monitored • 3 of 6 (50%)individuals had serious side effects including elevated liver enzymes and thrombocytopenia A series of recommendations were included as part of the DUE, however, the 7/25/12 P&T minutes did not document the development of a corrective action plan nor was there any follow-up of the corrective actions in the December 2012 P&T meeting. Additionally, the results of the DUE indicated that there were possible suspected ADRs associated with the use of phenytoin. These potential problems were not explored through the ADR process. It was reported that an inservice was provided to medical and nursing, but documentation was not submitted.	Noncompliance

		Lithium DUE The Lithium DUE was completed in September 2012 and presented at the December 2012 Pharmacy and Therapeutics Committee meeting. <u>Methods</u> Thirty individuals were receiving lithium. Individuals were selected if there had been a QDRR conducted on them during the first or second quarter using the new QDRR tool. A total of 17 individuals met this criterion and were selected for review. <u>Results</u> The data were reported in the DUE: • 17 of 17 (100%) individuals met criteria for use indication • 17 of 17 (100%) individuals met dose criteria • 15 of 17 (88%) individuals had current MOSES evaluations • 16 of 17 (94%) individuals had current CMPs o 10 of 17 had elevated serum sodium levels o 2 of 17 had elevated serum potassium levels o 3 of 17 had elevated serum chloride levels o 3 of 17 had elevated BUN levels • 16 of 17 (94%) individuals had CBCs o 4 of 17 (24%) had had neutropenia • 6 of 17 (35%) individuals did not have the required EKG in the records The monitoring team had several concerns related to the DUEs: • The rationale for the chosen methodology for both DUEs was not clear. The decision to include only those individuals who had a recent QDRR completed resulted in those individuals who were not recently assessed, once again, not benefiting from review. • The abnormals labs for both DUEs were not reported as suspected adverse drug reactions. • The neurologic and psychiatric side effects were not reported as suspected ADRs. • The findings of the lithium DUE were known in September 2012, but were not addressed and corrected until discussed in the December 2012 Pharmacy and Therapeutics Committee meeting. The findings should have been presented no later than the October 2012 meeting. • A review of QDRRs showed that some individuals lacked EKGs or had outdated EKGs at the time of the QDRR review and the issue was not addressed in the QDRR. Other deficiencies related to lithium use are discussed in N2. Overall, the DUEs provided information that had the ability to positively impact medical care. The facility must ensure that processes are implemented that allow this information	

		to be transferred to the medical providers in a prompt manner. It will also be important to follow the facility's procedure for conducting the DUE. The P&T Committee, which provides oversight for the process, should be involved in the selection of indicators, development of the data collection form, selection of sample size, and setting the thresholds for compliance. The recommendations and specific corrective action plans should be thoroughly documented in the P&T Committee meeting minutes and/or attachment. Meeting minutes should also document follow-up to closure of recommendations generated by DUEs. This provision remained in noncompliance.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The facility continued to report medication variances. Monthly meetings continued. The Medication Variance Performance Improvement Team converted to a Performance Evaluation Team in April 2012. Interviews with the pharmacy staff and attendance at various meetings contributed to the monitoring team's understanding of the problems that continued to challenge the facility. Several reconciliation processes remained in place. Medications were exchanged weekly. The initial count occurred in the pharmacy. During that time, the pharmacist, and nurse counted all medications. Once the medications were placed in the homes, nurses conducted medication counts daily at 2 pm. It was reported that very few medications were returned to the pharmacy with no explanation, however, the pharmacy department could not provide any precise information on the number of medications returned to the department. A review of medication variance meeting minutes showed that there was documentation that some medications were being returned to the pharmacy, but numbers were usually provided. Medication Variance PET meeting minutes dated 4/23/12 documented that on one Friday, 23 meds were returned to the pharmacy with no explanation. The problems of the medication variance system were not limited to reconciliation issues. The monitoring team attended the medication variance meeting that was conducted during the December 2012 compliance review. The meeting focused on the data for October 2012 (September 2012 variances). It was reported that the meeting was not a typical one. The monitoring team appreciated the information because the meeting observed was unorganized and was not conducive to critical thinking and data analysis. Participants were initially not provided copies of data for review. The data presented appeared inaccurate, were confusing to many attendees, and required multiple corrections back and forth between the CNE and the NOO. The monitoring team eventually received amended October 2012 data following the compliance review that differed from what was discussed in the meeting.	Noncompliance

Overall, the data format was difficult to follow and did not lend itself to any sort of longitudinal analysis or trending because each month was presented on a separate page. It was important for the facility to have accurate data given that in recent months a new issue related to holes in medication MARs had surfaced. In August 2012, the NOO noted that several homes had holes in the medication MARs. The following month, a 100% audit was conducted and it identified several hundred holes. Upon reconciliation, which was accomplished by comparing the number of MAR holes with the 2 pm count sheets, the actual number of errors was significantly reduced. For the month of September 2012, the actual number of errors was reported to be 17, however, this could not be determined by looking at the data. It was reported that omissions were the biggest problem. The data provided in the summary charts is presented below.

Medication Variances 2012							
	May	Jun	July	Aug	Sep	Oct	Nov
Total	25	9	5	5	65	434	317
Wrong Administration/Technique	8	0	0	0	53	416	--
Omissions	5	2	4	4	6	11	--
Medical Providers	0	0	0	0	0	0	--
Pharmacy	2	.5	0	0	.5	9	--

The magnitude of the problem related to medication variances was unknown, in part, due to a lack of reporting. As noted above, there were no prescribing errors reported. Some, but not all, of the clinical interventions were variances. The pharmacy director reported that he was unaware that items addressed in the clinical interventions should be reported as medication variances. However, it was noted that the medication variance minutes, dated 8/21/12, documented discussion about this requirement.

As done during previous reviews, state guidelines pertaining to medication variances were reviewed with the pharmacy staff. Per SSLC Medication Variance Guidelines dated 1/24/12, "Category A medication variances must be documented and counted with the total medication variances, whether they are 'potential errors' in the pharmacy, with medical or with nursing." The clinical interventions log included several entries that should have been reviewed as possible medication variances:

- 10/18/12 – Wrong dose of Cipro
- 7/3/12 – Possible PCN allergy
- 7/13/12 – Ciprodex ordered for eyes
- 9/18/12 – Tylenol allergy?
- 9/26/12 – Allergy to Combigan drops
- 8/1/12 –Prescribed Bactrim with sulfa allergy

		• 8/21/12 – Prescribed Pepto-Bismol with allergy • 6/4/12 – Prescribed Cipro when listed as allergy There were no medication variance forms submitted for any of the above incidents. In many instances, the documentation in the clinical interventions log was not entirely clear. Because these issues were not addressed, there was no compelling evidence that appropriate analysis of data or corrective action had occurred. SGSSLC appeared to have ongoing issues with documentation of allergies, which needs to be addressed. Over the past two years, many processes had been implemented with positive results, including the initiating of pharmacy-nursing medication counting, implementation of unit dose medications, and improved reconciliation of medications in the home areas. Based on the observation of the medication variance and other meetings, interviews, and document reviews, it appeared that quite a bit of additional work was still needed to develop a medication variance program capable of adequately detecting medication variances across the spectrum of the medication use system. Accomplishing this will require the collaborative efforts of the medical, nursing, and pharmacy departments with all sharing a vision of ensuring safe and effective medication therapy for the individuals at SGSSLC. The monitoring team offers the following recommendations: • All variances must be captured and appropriately assigned to disciplines involved • Each discipline head should report its variances at the committee meeting and provide a report of the corrective actions that have occurred. Documentation, inclusive of signature sheets should be provided at this meeting. • The pharmacy department must track internal departmental errors per technician in addition to external pharmacy errors. • The pharmacy must maintain retrievable data on the number of medications that are retuned to the pharmacy. • The state medication variance policy should be reviewed by the committee to ensure that medication variances are reported as required. • Problems related to physician order writing must be addressed. This will require an analysis of the contributory factors as well as a review of current processes. • Reports of medication room audits and medication pass observations should be regularly presented at the medication variance meetings. • The facility must maintain adequate documentation of overages/shortages to assist in detecting unreported variances. This data should be routinely presented at the Medication Variance Committee meetings. • The pharmacy director should ensure that there is reconciliation of all non-pill medications. Adequate documentation of the findings should be maintained. • The committee needs to reorganize its data presentation in a manner that allows for better analysis and trending This provision remained in noncompliance.	

Recommendations:

1. The facility will need to take a number of steps in order to move towards compliance with Provision N1. The monitoring team offers the following recommendations for consideration:
    a. The documentation of communication with prescribers should be increased. The log should include the pharmacist involved, the prescriber who is contacted, the time of contact, and the resolution of the problem.
    b. There should be clear documentation of any communication with prescribers related to drug allergies as per facility policy.
    c. The pharmacy director and clinical pharmacist will need to collaborate with the medical director/medical staff to expand the list of drugs monitored as part of the Intelligent Alerts.
    d. The pharmacy director must ensure that the Intelligent Alerts module is being utilized correctly and in accordance with state issued guidelines. The pharmacy director should print reports on a regular basis to ensure that the monitoring is occurring as indicated. Reports should also be reviewed regularly with the medical director.
    e. The Prospective Review of Physician Orders Policy should be revised to include the requirement for the Intelligent Alerts (N1).

2. The following actions should be taken into consideration with regards to the QDRR:
    a. As noted in the body of the report, the QDRR Report should comment on every medication that is included in the lab matrix. The exact value should be provided with the date as well as an indication of the range of values.
    b. The worksheet should be revised for continued use as discussed in the body of the report.
    c. The comment section of the report should provide concise and clear statements regarding clinically relevant information.
    d. The clinical pharmacist will need to capture relevant clinical recommendations that are clearly identified. Recommendations should cover all areas including the reduction of polypharmacy and anticholinergic burden.
    e. The psychiatry staff should review all QDRRs that involve the use of psychotropic agents in accordance with state guidelines.
    f. The pharmacy director and clinical pharmacist should review additional recommendations included in the body of this report (N2, N3).

3. For individuals who received new generation antipsychotics, the QDRR report should document the monitoring parameters and provide a synopsis of the risk for development of metabolic syndrome and any potential to mitigate risk (N3).

4. The facility should proceed with implementation of the tracking tools designed to track the QDRR process and response of providers. The clinical pharmacist should track the responses of the medical staff to recommendations made in the QDRRs. Much of this should occur through subsequent QDRRs. High priority recommendations should obviously receive closer follow-up (N4).

5. All medical staff must receive proper training on the MOSES and DISCUS evaluations and understand the requirements for completion (N5).

6. The primary care physicians should review the information included in the MOSES and DISCUS evaluations and utilize, as appropriate, the information in clinical decision making. Consideration should be given to including this information in the annual and quarterly assessments (N5).

7. The facility should provide the MOSES and DISCUS evaluations to the consulting neurologists for use during consultation (N5).

8. Recommendations for the ADR process are provided in the body of the report (N6).

9. The P&T Committee should be involved in the selection of indicators, development of the data collection form, selection of sample size, and setting the thresholds for compliance for DUEs (N7).

10. The recommendations and specific corrective action plans should be thoroughly documented in the P&T Committee meeting minutes and/or attachment. Meeting minutes should also document follow-up to closure of recommendations generated by DUEs (N7).

11. The facility must ensure that an adequate medication variance system is in place. This will require reporting of variances for all disciplines and demonstration that appropriate corrective actions have occurred. Additional recommendations are provided in the body of the report (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o SGSSLC client list o Admissions list o PNMT Staff list and Curriculum Vitae o Staff PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Physical Nutritional Management o Section O QA Reports o PNM Draft Policy (9/14/12) o Dental Care – Suction Toothbrush policy (Revised 5/24/12) o Protocols Related to Choking Incidents/Abdominal Thrusts/Coughing Episodes (Revised 6/28/12) o Integrated Clinical Services and Minimum Common Elements of Clinical Care (9/13/12) o PNMT Evaluation template o PNMT Referral form and criteria o Sample referral forms completed o PNMT Meeting documentation (6/1/12 to 9/28/12, 12/5/12) o Daily Provider Meeting minutes submitted o Skin Integrity Team minutes o PNMT Assessments (Individual #40, Individual #104, Individual #77, Individual #178, Individual #112, Individual #251) o PNMT Episode Tracker Trigger summary o PNMT Episode Tracker o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Effectiveness Monitoring Tool template o Completed Compliance Monitoring sheets submitted o Completed Effectiveness Monitoring tools submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades

	o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months (10/17/12) o Individuals with Pain o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 12 Months o Non-Injury Falls (10/1/11 – 10/16/12) o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans) o PNMPs and sample picture pages submitted o APEN Evaluations: • Individual #217, Individual #90, Individual #203, Individual #98, Individual #278 (2), Individual #146 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. o PNMP section in Individual Notebooks for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76,

	Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Maria DeLuna, RN o Judy Perkins, PT o Erin Bristo, MS, CCC-SLP o Deanna Worden, RD, LD o Joel Bessman, MD o Scott Lindsey APN o Adjunct members, nurse case managers, QDDPs, home managers who attended PNMT meeting o Various supervisors and direct support staff o PNMT meeting o ISP Meeting for Individual #127 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas o OT/PT Treatment Rooms o Dysphagia Treatment (SLP) for Individual #202 o Suction toothbrushing for Individual #288
	Facility Self-Assessment: In the self-assessment, Dena Johnston, OTR, the Rehabilitation Therapies Director, outlined specific self-assessment activities and provided specific data based on the findings from these activities. The activities were similar to the process used by the monitoring team, and included many of the same or similar key elements used for review and outlined in this report. She continued to demonstrate significant understanding of this process and this likely drove the success and progress they experienced with this provision over the last six months. O1 through O8 were not found to be incompliance by the monitoring team as outlined below. This was consistent with the findings by the facility. Excellent progress, however, was made in each of these and the

	"measures of success" will ensure continued movement toward compliance. The data reported clearly related to each of the provision sections and were logically presented. This allowed the department to readily track their own progress and compare their findings with that of the monitoring team. The director's approach to this process continues to be more refined and improved with each round of monitoring. The extensive action plans (112 steps across the eight provisions) developed were on point and should assist the department in moving along the continuum toward substantial compliance. It was impressive that nearly 60% of these were completed and another 30% were in process as of 11/16/12. There were a number of measures of success that had not yet been implemented. These plans and strong leadership were likely significant factors in the consistent progress made with this provision despite the limitations of staffing. A very strong foundation had been laid for PNM supports and services delivery at SGSSLC.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, though the only dedicated team member was the nurse. Each of the members had been participating on the team since the previous review. Back-ups had been identified and should result in improved attendance at the near-weekly meetings held. They had completed a number of assessments in a timely manner. The two most current ones represented significant improvements. During the meeting that the monitoring team observed, the discussion was very good related to follow-up on individuals currently active and the participation by the IDT members was much improved. There appeared to be a significant delay/absence of referrals of individuals who would benefit from PNMT evaluation, though this was addressed through training and the establishment of specific criteria. The facility must review the existing databases that identify individuals with key health issues in order to effectively track them and to watch for facility-wide trends. Individuals who require PNMT referral may be more effectively identified and in a timely manner. These lists should be developed cooperatively by the facility. They must be accurate and routinely updated. These lists are not for use only by the monitoring team, but should be used by the facility to direct actions needed on an individual basis, but to address systems issues as well. These should be also routinely used by the PNMT during their reviews. There have been some good efforts upon which to build. The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators or with incidences of these concerns. They routinely tracked their status in an organized manner with clearly stated outcomes and exit criteria. Follow-up of individuals for whom they provided assessment/review of was consistent and well documented. The status with regard to outcomes and exit criteria should be reviewed routinely as well. In addition, there were several content items that should be considered to round out the new assessment format and guidelines. An audit tool for these was planned and the monitoring team looks forward to seeing this next time. Mealtimes and position and alignment were improved, though some issues related to the organization and

	efficiency of the dining rooms were evident. There was very limited space and home staff were responsible to plate and serve the meals. In some cases, this was done in and around individuals who were trying to eat and staff who were attempting to assist them. Needless to say, this resulted in errors, poorly timed servings, cold food, violations of holding temperatures, poor hygiene practices, and potential for behavior problems for individuals who waited excessive amounts of time without being served their food. The mealtime environments, moreover, were not dynamic and pleasant environments, making what could be an ideal opportunity for skill acquisition, incidental learning, and communication, instead confusing and chaotic. This was not acceptable and should be evaluated and remedied promptly. Monitoring of staff compliance must be consistent and effective. Monitoring should answer the following questions: • Are staff trained to do what is needed? • Are they routinely expected to do what is in the plan by supervisors? • Are staff doing the right thing even when they think no one is watching? If staff have demonstrated competency, there must be an expectation that the plan be implemented as written every time. This practice reinforces the training or otherwise staff forget and must be retrained. This takes away from valuable time that could be devoted to other important tasks. This must be a clear expectation from the facility administration, unit directors, homes managers, and supervisors. While there were notable improvements and pockets of excellence, there continued to be significant needs in the provision of supports. The facility as a whole must identify these and address them effectively in order to move forward in this section.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally	Core PNMT Membership: The current core team members of the PNMT included Maria DeLuna, RN, Judy Perkins, PT, Dena Johnston, OTR, Erin Bristo, MS, CCC-SLP, and Deanna Worden, RD, LD. Each of the team members was the same as during the last review and the facility is commended for maintaining this consistency. In addition, back-ups for each member had been identified, with the exception of the dietitian. The dietitian was a part time contractor and the only dietitian for the entire facility at the time of this review. She currently worked one to three days per week only. Another contract dietitian was scheduled to begin in January 2013 and work for nine months. The facility continued to seek a full time dietitian and was planning to request a second position. The RN was the only team member assigned full time to the PNMT and each of the others had additional caseload duties. Ms. Perkins was one of two PTs assigned to provide supports and services to each of the individuals in addition to her responsibilities on the PNMT. Ms. Johnston was the Habilitation Therapies Director with significant additional responsibilities. Ms. Bristo was responsible for mealtime and dysphagia issues for all the individuals living at SGSSLC. Medical Services members included Joel Bessman, MD, and	Noncompliance

#	Provision	Assessment of Status	Compliance
	accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Scott Lindsey, APRN, FNP. They participated per their assigned caseload. Adjunct members included nurse case managers, the QDDPs, home managers, DSPs, PNMPCs, and other team members as indicated. <u>Continuing Education</u> Continuing education was documented for some of the current core members of the team in the last six months and included the following. Some were attended by one or more core team members: • Enteral Feeding Safety (one hour) • Enteral Feeding Tubes: A Guide for Nurses (3 hours) • Gus Eckhardt Trauma Symposium (6.6 hours) • Effective Management Strategies for Chronic Constipation (one hour) • Medical-Surgical Nursing Certification Review Course (7 hours) • Annual Habilitation Therapies Conference (13.5 – 17 hours) • PNMT Training (5.5 hours) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (10 – 17.5 hours) • Role of the Dietitian on the PNMT (1.5 hours) • Autism, Asperger's, SPD and ADHD (6 hours) • Medication Training for Nurses (6 hours) The monitoring team commends the facility in its support of all clinicians participating in continuing education. This should include both state-sponsored education and alternate sources as well to ensure appropriate breadth of content for all PNMT members. The only back-ups to participate were the OT and PT. This should be considered for the other back-ups as well. It is critical that this team continue to achieve and maintain the highest possible knowledge and expertise in the area of PNM. Cross-training in areas traditionally viewed as pertaining to a specific discipline would also be highly useful to enhance team building and the interdisciplinary approach. <u>Qualifications of Core Team Members</u> The credentials of each licensed team member and back-up was verified as current online. Each of the core team members had documented experience of three or more years in the provision of services in their field for individuals with developmental disabilities and PNM with the exception of Deanna Worden, the dietitian. Per her CV, she had been a diet technician at the local hospital for three years, then became as a registered clinical dietitian for three years. She provided services as a contractor during the last year with no previous experience with individuals with developmental disabilities. The previous dietitian had extensive experience and the PNMT had worked with her for some time. Continuing education opportunities should be provided to further address this gap in her	

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		experience. PNMT Meeting Frequency and Membership Attendance There was documentation related to 18 core team meetings held from 6/1/12 through 9/28/12. Weekly summaries were submitted for the following meetings: 6/1/12, 6/6/12, 6/15/12, 6/22/12, 6/29/12, 7/6/12, 7/13 and 7/18/12, 7/20/12, 7/27/12, 8/3/12, 8/10/12, 8/17/12, 8/24/12, 8/29/12, 9/7/12, 9/14/12, and 9/28/12. There were no signature sheets of attendance submitted. Attendance of core team members based on the weekly summaries submitted was as follows: • RN: 89% • PT: 94% • OT: 94%, improved from 90% during the previous review • SLP: 94% • RD: 72%, improved from 65% • Medical: 78%, improved from 50% Some of these included attendance by a designated back-up. This attendance frequency was acceptable for all core team members with the exception of the dietitian. Though not a required element, participation by medical staff was often vital to the effectiveness of the PNMT meeting. The consistency of attendance by the medical staff was impressive and, as observed during this onsite review, the participation by Dr. Bessman and Scott Lindsey was excellent. Back-up clinicians should be in attendance in the absence of any core team members, so that effective meetings may be held to address issues for the individuals served with high PNM needs and significant at-risk concerns. Additional IDT members consistently attended each of the PNMT meetings for which weekly summaries were submitted. The monitoring team observed significantly more participation by these team members likely due to changes in the meeting format implemented after the previous review. Role of the PNMT: Facility PNMT Policy The PNMT did not act outside of the IDT. The initial meeting included an IDT meeting in which risks, rationales, and action plans were discussed, refined, and assigned. The PNMTs function was described as to provide support to the IDT including the provision of education and knowledge to the IDT via recommendations, evaluation, and treatment as indicated. Action plans were the responsibility of the IDT in conjunction with the PNMT and these plans were integrated into the risk action plans. The local draft policy of the PNMT process described PNMT member roles and responsibilities, though did not address the referral process. A referral form was submitted that was used by the IDT for referrals to the PNMT. This outlined the specific	

#	Provision	Assessment of Status	Compliance
		issues or concerns that warranted referral. There was also a list of criteria that may be used by the IDTs to guide their decision making related to referrals to the PNMT. The monitoring team's findings indicated that all team positions were filled and remained unchanged in the last six months. While the team was fully staffed, attendance by the dietitian was inadequate for appropriate assessment and review of individuals at highest risk. It was not possible to fully evaluate the attendance of all team members over the last six months as a limited number of weekly summaries were submitted for review. Back-up positions had been established, but their attendance was not noted in the weekly summaries available for review. As described below, continued improvements in the integration of the PNMP into the ISP and consistency of implementation was indicated for substantial compliance with this provision.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>PNMT Referral Process</u> The PNMT received referrals from the IDTs, though most were self-referrals. There was a referral form requesting basic information about risk levels and changes in status that warranted the referral. A list of criteria for referrals of individuals who were deemed to be unstable constituted placing them on the active caseload of the PNMT and included: • Hospitalizations for aspiration pneumonia • Two or more Stage II wounds in one year or any Stage II, IV, or non-healing wound • Significant unplanned weight loss • Hospitalization related to bowel obstruction • Unresolved triggers for aspiration • New tube placement, proposed tube placement or transition from enteral nutrition to oral intake • Unresolved vomiting • Two choking incidents in one year • Unresolved falling incidents (more than three per month) • Fractures of long bone, spine, hip or pelvis, abnormal MBS, upper GI or EGD, and hospitalizations for GI bleed requiring assistance or assessment by the PNMT • Any PNM issue not successfully resolved by the IDT for PNM-related High risk areas Based on the documentation submitted, there were only PNMT self-referrals generated with none initiated by the IDT, through September 2012. Referral forms submitted for three individuals (Individual #21, Individual #104, and Individual #40) were reviewed. These appeared to be generated by the IDTs and reflected a positive trend that should continue.	Noncompliance

#	Provision	Assessment of Status	Compliance
		There was a question on the form that asked if the IDT was seeking additional input or solutions to meet the individual's PNM challenges. In the case of Individual #21, the IDT responded "no." As this was the primary support provided by the PNMT, it was not clear why this question was even posed to the team. Referral to the PNMT should be a consideration during annual ISP meetings for any individual deemed to be at high risk for PNM-related concerns and during ISPAs addressing the incidence of any of the issues listed above. Training related to the PNMT referral process had been provided to the IDTs and referrals had gone from none in September 2012, to six in October 2012, and four in November 2012. The therapists had also begun to take a PNMT referral form with them to the ISPs in order to prompt the IDTs to consider referral to the PNMT when the criteria were met for referral. This will only be an effective process if there is a therapist present at the ISP/ISPA meetings. There had been an effort to assign either and OT or PT to these meetings based on the focus of supports provided. The PNMT reported 18 individuals as an active caseload based on the weekly summaries for 18 meetings. One was identified to be on oversight status and three to be on monitoring status. The weekly summary submitted for the meeting held during this onsite review identified two additional individuals for whom assessments were submitted and discussed below. Follow-up was generally consistent and timely in that the next review was documented in the weekly summary. Documentation was noted in the subsequent summary. Completion of recommendations and outcomes were not consistently documented, however, in order to close the loop on identified needs. A PNMT meeting was observed by the monitoring team. Extensive reporting and participation by the IDT was noted. The meeting was generally well-organized and there was productive discussion and participation by all team members. The meeting minutes were consistent and easy to follow. Specific measurable outcomes and/or exit criteria were established for most of the individuals, beginning with the weekly summary for 7/27/12. Review of the status of these outcomes should be consistently documented, for example, on a monthly basis or other designated interval. The number of individuals with specific PNM-related concerns (and potential needs for supports and services by the PNMT) included, but was not limited to the following examples: • Chronic dehydration: (1) • Chronic respiratory infections: (10) • Fecal impaction (3) • Weight loss of 10% of more over six months: (6) • BMI equal to or less than 20: (18, with nine of these with BMI below 18.5 or underweight status)	

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		• BMI equal to or greater than 30: (60, 18 of these had BMIs of 40 or over, or morbid obesity and one was 65.7 or morbidly obese). Obesity was reported in 27% of the census. • Required mealtime assistance (115) • Poor oral hygiene (16) • Aspiration and/or pneumonia incident in the last six months: (35, only two of which were viral, all others were either bacterial or aspiration pneumonia • Falls with serious injury: 16 • Fractures: (6, though none were for individuals in wheelchairs or required assisted ambulation) • Three or more falls, with injury in 12 months: (61, 13 of which involved a serious injury. Over half of these individuals had experienced five or more falls with injury. There were also a significant number of these individuals with additional multiple falls that did not result in injuries) • Non-ambulatory status: (22) • Required wheelchair as primary mobility: (28) • Required transport wheelchairs: (15) • Required ambulation assistive devices: (23) • Required orthotics and/or braces, orthopedic/custom shoes: (77) A number of individuals presented with issues in multiples categories of PNM concerns. A PNMT Trigger Summary was created to address very specific events related to PNM supports. This list was extensive and identified 32 distinct health issues. It was associated with a PNMT Trigger Log that identified the individuals who presented with these. The PNMT should not be solely responsible for maintaining these, but instead there should, in fact, be some type of collaborative facility effort to maintain this or a similar database of key health clinical indicators. The PNMT should have access to and utilize these routinely. This is a great effort in the direction needed for appropriate identification of individuals with PNM needs. Specific PNM-related elements were also tracked for individuals in the PNMT weekly summaries, so that the PNMT could track established thresholds for specific incidents or health events in order to permit individuals to be identified sooner for referral and assessment. These included hospitalizations, changes in health status, choking, increased coughing episodes, occurrence of pneumonia, occurrence of skin breakdown, incidents of falls and fractures, weight loss, and dypshagiagrams. This information was gleaned from morning reports attended by the PNMT RN as well as from other sources. This continued to be a process that tended to examine occurrence in isolation, rather than trending the occurrence for specific individuals, occurrence facility wide, and over time. The new logs, however, were a significant step in addressing this. Collaboration across systems is	

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		indicated to include incident management, risk management, QA, and others. The self-assessment for this aspect of this provision included a report of incidence of choking (8 in six months), aspiration (3 in six months), weight (143 over three months, parameters of data collection were not defined), falls (9 in two months, though this was not consistent with the falls report submitted), and pneumonia (17 in six months). The analysis indicated that there was an increase in occurrences for choking and pneumonia, though it was not clear if this meant over the six-month period, from the same time period last year, or from the previous six months. This type of analysis is a good first step, however, in using a centralized data system as previously described. <u>PNMT Assessment and Review</u> PNMT Evaluations for Individual #251, Individual #178, Individual #112, Individual #77, Individual #40, and Individual #104 were submitted for review. The referral dates for these assessments were as follows:	

Name	Date of Referral	Date of Assessment	Final Signature Date
Individual #251	unknown	unknown	unknown
Individual #178	unknown	unknown	unknown
Individual #112	7/13/12	unknown	unknown
Individual #77	unknown	unknown	unknown
Individual #40	11/1/12 (physician's order 10/22/12)	11/7/12	11/30/12
Individual #104	10/15/12	10/15/12	11/29/12

The assessments for Individual #40 and Individual #104 were completed within 30 to 45 days, that is, acceptable and timely. This was not known the other four assessments. The referral date and the date that the PNMT evaluation was initiated should be clearly documented. The signature dates should be the date that the assessment was finalized by the team members. This makes tracking of these timelines possible.

The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. The assessments submitted for Individual #40 and Individual #104 reflected a revised assessment format intended to address these elements. The other assessments were not reviewed for format because they were completed prior to implementing the new template. Based on review and based on

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		discussion during a pneumonia committee meeting, findings included: • The date and reason for referral to the PNMT was clearly stated. • The health risk ratings established by the IDT at the time of the assessment were reported, though only some were listed rather than all of them. Due to the relationship of all the risk ratings, each should be reported, though extensive discussion may be limited to those considered to be high and medium. • The clinical diagnoses were listed. • A medical history was listed, though it was not known over what time period. • Medications were listed, though doses and start dates were not. Changes over only the last three months were identified. Additional changes over the last year may be relevant when looking at trends or antecedents to changes in health or functional status and should be included. These omissions were apparent during the discussion by the pneumonia committee. • There was a review of potential drug/drug interactions, but not actual side effects experienced by the individual, nor were drug/nutrient interactions addressed. • Though potential side effects of medications were identified, there was no report of actual side effects experienced by the individual, if known. • The review of current supports was extensive for Individual #104, but very limited for Individual #40. • Identified assessments were listed with dates, with a limited summary of the findings. The identified assessment needs were also listed serving as an action plan for the PNMT. This should drive the clinical data reported in the assessment, though additional assessment or diagnostics may also be identified and be listed as recommendations. • A nursing physical examination was documented. This should be limited to clinical data only, however, with considerations or recommendations reserved for the analysis section of the report so they were not overlooked. • Though nutritional assessments were identified as a need for both individuals, this was noted only for Individual #104. • Additional areas included in the assessment data included a review of Aspiration Trigger Data, dental, and PNMT special monitoring findings. • A section describing the individuals functional strengths was reported which would permit the team to build on these in the development of action plans to address the identified needs or risks. • The analysis was significantly improved over previous assessments, but as stated above, important key data were not included in the analysis. For example, for Individual #40, the nursing assessment identified potential medication side effects related to increased sedation that may be impacting his functional mobility. This was merely referred to as “possible medication side effects” rather than specifying the medications of concern.	

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		• There was no evidence that the PNMT observed transfers or toothbrushing. Each of the elements of the current PNMP should be evaluated for effectiveness and implementation. • There was no assessment of height, weight history, intake, or nutritional needs evaluated. • The analysis of findings was greatly improved for Individual #40. The analysis for Individual #104, however, continued to be more of a summary of the data presented in the report. Ideally, the analysis should present the rationale for all recommendations. Issues raised in the analysis should generally have an associated recommendation to ensure resolution. o For example, the need for individualization of aspiration triggers for Individual #40 was mentioned in the dysphagiagram section of the report, but was not mentioned in the analysis. It was, however, listed as an action step under recommendations. Conversely, issues related to potential sedation side effects of current medications were mentioned in the nursing section of the report with a recommendation to consider review of his medication regimen. The analysis stated that assessment data identified possible side effects, but there was no recommendation listed in the action steps about this. o In the case of Individual #104, the mobility portion of the assessment referred to a recent PT evaluation and direct PT was initiated. There were no data related to baseline, PT goals, the effectiveness of interventions, or specific recommendations to continue. o The PNMT should consider limiting the analysis and recommendation statements to those sections of the report so as to ensure they are all captured and considered in the total picture of the individual's needs and in the development of an intervention plan. There is an urgency to complete PNMT assessments that are thorough, current, and accurate, and to implement appropriate and effective interventions to address the identified needs for individuals. This should be completed in 30 days, at most, though some interventions may be implemented immediately based on evaluation findings before the written report is finalized. It is critical that the assessments be completed in a timely manner because these individuals had significant identified needs for supports and services to address PNM health concerns. The referral to the PNMT is to capitalize on the collective expertise of the team members in order to see the problem in a new way and to identify new strategies to address ongoing issues that had not yet been resolved. The SGSSLC PNMT appeared to understand this responsibility and was certainly moving along the continuum toward compliance with this aspect of O2.	

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		Risk Assessment Risk rating tools and/or action plans were submitted for the 20 of 21 individuals (95%) in the sample for whom individual records were requested. These tools were to be completed by the IDT at the time of the annual ISP with routine review after hospitalizations or other changes in status. An action plan was developed to manage or mitigate identified risks. Fifteen individuals had both the risk assessment and an action plan. The other five had one or the other attached to the ISP. For the most part, risk ratings and the rationales provided were improved since the previous review. The teams appeared to do a better job of considering other issues that may predispose an individual to special health concerns. The instructions for the newly implemented Integrated Risk Rating Form (IRRF) indicated that the team should post all risk-related data for each risk factor, supports provided and the baseline to include current data and the efficacy of supports and services provided relevant to each risk factor. The baseline was described as essential because it often functioned as a predictor of an impending change in status. The IDT's discussion of each of these should provide the foundation for evidence-based decision making as to the need for a revision to the action plan. Only the IRRFs for Individual #112, Individual #203, and Individual #140 were completed using this revised version (form submitted for Individual #112 was missing pages). The IRRF for Individual #140 did not have an attached action plan. During the ISP meeting, the team was to discuss and analyze the baseline information, determine the risk rating with rationale, and identify individual triggers and criteria for IDT review. By report, SGSSLC department heads had participated in training related to the new risk rating process in Austin (September 2012). Local training was to be conducted by the state, tentatively scheduled for January 2013. The monitoring team looks forward to full implementation of the new IRRF in the next onsite review. The most common issue identified was that the IDTs generally did not consider new supports or interventions to mitigate identified risks, but rather indicated that they would continue the existing plan, even in cases where the individual had experienced health events that suggested the plan was not effective (Individual #21, Individual #104, Individual #203, Individual #7 and Individual #40). Issues related to Individual #203's IRRF and action plan included: • There was no rationale for the risk ratings assigned. Only supports were listed. For example, she was reported to be high risk for choking and aspiration, but there were no statements about her status or history that supported this. Baseline was stated to be PEG tube and GERD. An action plan item was identified to decrease the number of episodes of formula in her mouth through optimal	

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		positioning. There was no statement as to how often this was occurring at the time this action plan item was developed. • She was listed at high risk for weight and described as weighing more than 10% above the upper range of her ideal body weight. She was enterally nourished, so managing her intake would be a matter of controlling calorie intake (unless there was an issue with fluid retention and edema). There was nothing in her plan to address this, though there was a goal that she would not gain or lose more than two to three pounds per month over the next year. If she were to meet that goal, however, she could lose as much as 36 pounds or gain 36 pounds. There were no specific action steps to evaluate this. Though she was to be referred to the dietitian as needed, this was not specified. • She was identified with osteoporosis and osteopenia and required full assistance for mobility and stand pivot transfers, yet she was identified only at medium risk for fractures and falls. • She was identified as medium risk for fractures, though the baseline statement indicated that due to her chronic asthmatic and bronchitis condition, she was always at risk for infection. • She was identified at only medium risk for skin integrity concerns, though she was described as seated in a custom tilt-in-space wheelchair, was incontinent, non-ambulatory, dependent for mobility and self-care, had dry skin secondary to hypothyroidism, and wore an AFO brace on the right. A few issues related to Individual #140's IRRF were: • She was identified at low risk for dental, but the data presented were that she had only fair dental hygiene, and there was no rationale for this rating. • She was rated at low risk for constipation, yet there a significant list of risk factors that could result in constipation including inactivity, low activity tolerance, and hypothyroidism. • She was identified only at medium risk for cardiac issues, yet a list of risk factors were documented, including hypercoagulability, obesity, respiratory impairment, sleep apnea, COPD, previous C-pap use (new one on order), mild atelectasis, nighttime oxygen use, lymphedema, and inactivity. • She was identified at low risk of diabetes, yet was described as morbidly obese, with an abdominal girth of 50 inches, and inactivity. Individuals with lymphedema are cautioned to manage risk factors that may cause diabetes to prevent further complications from the combination of these two diseases. Many staff required prompts to answer questions related to risks. The continued to need to refer to a written plan to know what they were to look for in an individual for whom they were providing supports. Review of the plans and risks should be done when the	

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		staff were initially assigned for the day, but even so, staff should have an active knowledge of the individuals to whom they were assigned on any given day. For example, in the case of Individual #202, the staff assisting her at mealtime could not describe what steps to take in the event that she began to choke. This staff was not able to answer any questions asked by the monitoring team. • During the ISP meeting for Individual #127, the monitoring team observed the extensive discussion that took place related to completion of his IRRF. He had previously been rated at medium risk for aspiration and choking, but as a result of the team discussion, it was determined that he was actually at high risk for both. He was reported to take large bites, and eat too fast. He required a pureed diet, a small spoon, instructions for safe eating, and staff to sit next to him during meals due to unsafe eating. He was edentulous and had poor control of the food bolus for swallowing. He also required nectar-thickened liquids. Despite the lengthy discussion, there was no report as to monitoring results related to the effectiveness of his current PNMP/dining plan to address these concerns. There was also no report as to staff compliance related to appropriate implementation of these plans. On two occasions during this onsite review (one before the ISP and one immediately after this meeting), the monitoring team observed Individual #127 eating too fast and taking extremely large bites with no DSP intervention (see below). There were no measurable goals or objectives established for the next year related to either of these key risk areas as required by this assessment process.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>PNMP Format and Content</u> It was reported that 200 (90% of the current census) individuals at SGSSLC had identified PNM needs, but only approximately 147 individuals were provided PNMPs based. This discrepancy was not clear to the monitoring team. Comments below relate only to the most current PNMPs submitted for the individuals in the sample (21). Some improvements in the consistency of format and content were noted and are identified below, while most of the others remained consistent or decreased. Additional improvements in the implementation of the plans were also observed. • PNMPs for 21 of 21 individuals in the sample (100%) were current within the last 12 months. • PNMPs for 21 of 21 individuals in the sample (100%) were of the same format. • PNMPs for 21 of 21 individuals in the sample (100%) were consistent with the most current state-established format that included risk levels, triggers, and outcomes. • PNMPs for 21 of 21 individuals in the sample (100%) included a list of risk areas. These appeared to be related to the supports provided in the PNMP. Consideration for whether there is staff understanding that these may not be the	Noncompliance

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		only risks will be critical for staff training. There was also no indication on the plan whether the individual had an aspiration trigger data sheet. • In 0 of 21 most current PNMPs (0%), there were pictures other than of the individual. There appeared to be some picture pages with previous versions of the PNMPs, but it was not clear if they were associated with the most current PNMPs because the dates were different (Individual #203, Individual #66, Individual #40, and Individual #128). There were no pictures for any other individuals included in this sample submitted. These should be considered a key element of the plans and, if available, should always be associated with a plan. Some samples of picture pages for other individuals were submitted and these were noted to be excellent. They were large and clear color photographs with instructions. • In 20 of 21 PNMPs (95%), positioning was addressed. Positioning for Individual #112 was not described, though page two of his plan was missing. • In 4 of 4 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though this was very minimal and limited to primarily tilt for pressure relief. • In 20 of 21 PNMPs (95%), the type of transfer was clearly described. This was no addressed for Individual #66, though two of the three pages were missing. • In 20 of 21 PNMPs (95%), there was a distinct heading for bathing instructions. The bathing equipment was listed with staff assistance needed as indicated. This was also not noted for Individual #66 as described above. • In 0 of 20 (0%) of the PNMPs, toileting-related instructions were provided. • In 6 of 21 (29%) of the PNMPs, handling precautions or movement techniques were not provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. • In 21 of 21 PNMPs (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. Each also had a Dining Plan current within the last 12 months at the time of this review. • There were 3 of 21 individuals had feeding tubes. None of these PNMPs indicated the individual was to receive nothing by mouth (0%). • In 21 of 21 dining plans (100%), position for meals or enteral nutrition was provided via photographs. All of the pictures were large enough to show sufficient detail. There were no photographs associated with the most current PNMPs even for those who required full assistance of positioning and mobility. (Improved from 95%.) • In 18 of 18 PNMPs (100%) for individuals who ate orally, diet orders for food texture were included. • In 16 of 18 PNMPs for individuals who received liquids orally (89%), the liquid consistency was clearly identified.	

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		• In 16 of the 18 PNMPs for individuals who ate orally (89%), dining equipment was specified in the mealtime instructions section or it was stated that they did not have any adaptive equipment or used regular equipment. • In 21 of 21 PNMPs (100%), a heading for medication administration was included in the plan. This included positioning, adaptive equipment, diet texture and fluid consistency. (Improved from 95%.) • In 20 of 21 PNMPs (95%), oral hygiene, including general positioning and brushing instructions. Again, Individual #66's plan was missing pages. • 19 of 21 PNMPs (90%) included information related to communication. Each of these described how the individual communicated including use of AAC. Individual #66 and Individual #112 had missing pages in their plan. Some of these were excellent (Individual #77, Individual #222, Individual #21, Individual #104, and Individual #178, for example). Few described strategies for staff to use to communicate with the individual, however. Auditing of the PNMPs was currently conducted by the PNMPCs (a sample of eight per month) to ensure that all content areas were included and to ensure consistency of content. The self-assessment reported compliance with inclusion of the essential elements as follows for 2012: April 90%, May 91%, June 81%, July 82%, august 78%, and September at only 65%. There was no analysis in the assessment to explain why there had been such a large decrease in compliance with these. The average percentage of compliance for each of the 20 elements reviewed by the monitor was approximately 79%. Previously there had been a PNMP review committee and, by report, there were plans to reinstitute this group that included the therapists. This may likely be more effective to have the licensed professional staff analyzing these important plans. <u>Integration of the PNMPs in the ISPs/ISPAs</u> There were 20 ISPs submitted for the 21 individuals included in the sample selected by the monitoring team. Each was current within the last 12 months. ISP meeting attendance was as follows, remaining the same or decreased from the previous review with the exception of medical and psychiatry: • Medical: 45% (9/20), improved from 13% • Psychiatry: 35% (7/20), improved from 13% • Nursing: 95% (19/20) • RD: 15% (3/20), SGSSLC self-assessment identified 0% attended over six months April to September 2012 • Physical Therapy: 55% (11/20), SGSSLC self-assessment combined OT and PT attendance identified at 66% attended on average for six months • Communication: 20% (4/20), SGSSLC self-assessment identified 36% attended • Occupational Therapy: 15% (3/20), SGSSLC self-assessment combined OT and PT	

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		attendance identified at 66% attended on average for six months • Psychology: 95% (19/20) • Dental: 5% (1/20) • Audiology: 5% (1/20) It is not possible to achieve adequate integration given these levels of PNM-related professional participation in the IDT meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective action plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the team members is present to participate in that process. The Physical Nutritional Management Plan was reviewed in only 4 of the 20 ISPs submitted (20%). The content varied greatly. In some cases, the content was text lifted from the OT/PT assessment rather than a reflection of IDT discussion about the content and effectiveness of the plan, and recommendations for changes. Only the PNMP for Individual #85 identified specific issues and changes discussed. Though it was not specifically stated, it was presumed by the monitoring team that the other aspects of the plan were deemed to be effective for her. The essential elements guidelines established should be effective, along with the new ISP format which prompts this review, to ensure that the IDTs consistently review the plan as required. In addition there was a Section F Audit tool that included PNMP review currently in use. Continued oversight and review is needed to ensure consistency, yet individualization across ISPs and to assist the QDDPs in meeting this standard in their facilitation of ISP meetings and subsequent documentation of PNMP review and approval. Continued training for QDDPs was indicated to ensure an appropriate description of the annual and quarterly reviews. These should not be rote statements that the plan was reviewed, but rather a reflection of the discussion related to review, the effectiveness of the plan in meeting the individual's needs and addressing their specific PNM risks and the identification of necessary revisions.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals	<u>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with variable input by other IDT members as described above. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input were limited. There was evidence of ISPAs for required changes in the PNMPs. ISPAs were submitted for 15 of the 21 individuals in the sample selected by the monitoring team. Review of these revealed that there were single ISPAs for only four individuals related to changes needed in their	Noncompliance

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	shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	PNMPs, though each of these individuals had at least one revision to their PNMP and some as many as eight or nine (Individual #40 and Individual #128), with an average of four revisions to each individual's plan in the last year. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve IDT involvement in the development of the plans. The PNMP should be reviewed during all ISPs (and most ISPAs) to determine if any of the outcomes require a change to the plan. Dining Plans were available in the dining areas. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair, if he or she had one, or was readily available nearby. General practice guidelines (foundational training) with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in NEO and in individual-specific training by the therapists and PNMPCs. <u>Observations</u> There was continued improvement related to mealtimes in the homes observed by the monitoring team. There were only a few notable concerns related to implementation and presented below: • Individual #273: She could not sit close enough to the table due to a large arm rest on the right side of her wheelchair. • Individual #268: Her foods were to be moist so she could swallow easier, and she was to be served gravy or broth with her meals. This was not provided and staff had to be prompted to do so. • Individual #78: Cookie pieces provided were too large, though they were soaked in honey thickened milk. A PNMPC was assisting him and stated that he made sure the pieces were soft, but had to be directed to make the pieces smaller and consistent with his diet order. • There was insufficient staffing noted in 510A for lunch. There were 16-17 men on the home, with eight staff on duty that day. However, one staff was pulled to accompany one of the men to the hospital. Another was pulled for a random drug test. There were four 1:1 assignments, thus leaving only two regular staff to assist the other 12 individuals for their meals. Many of them required assistance and supervision throughout the meal. This could not be adequately provided with this ratio. • Individual #25: She was verbally prompted to take a drink, though she did not. The dining plan stated that she was to be encouraged to take drinks and alternate bites with sips of fluid. No further prompts or strategies were used to ensure that this happened. • Individual #127: The DSP assigned to assist him was lying on his elbows, directing him to take smaller bites. The staff was not appropriately engaged with	

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		Individual #127. The Habilitation Therapies Director provided coaching for strategies to use an extra spoon to ensure that Individual #127 did not take too large a bite at that time. Later, the same DSP was observed being equally disengaged and not using the strategy taught to him by the director. Again Individual #127 was observed eating rapidly and taking extremely large bites. During his ISP meeting, there had been significant discussion about his high risk for aspiration and choking. When two members of the monitoring team entered the dining area, the staff made no effort to appropriately intervene or ensure Individual #127' safety during this meal and there was no dining plan on the table. These concerns were reported to the home manager on duty who had also just returned from the ISP meeting. This same DSP had been identified in a number of previous monitoring team reviews as not adhering to the PNMP and dining plan for other individuals in that home also reported to supervising staff. • Individual #126: Her diet order prescribed ground foods, yet she was served pureed carrots. • Individual #345: His diet order prescribed chopped foods, sized ½". Pieces of meat and pineapple served were larger than that. Positioning and alignment were also improved. Very few concerns were noted. Other observations included: • Individual #203: She was observed to be not well-positioned in her wheelchair and was seated too low as per her headrest. Staff initiated re-positioning before needing to be prompted to do so. • A modified dining chair located in 510A was very dirty and needed cleaning. Oral hygiene was another area of concern for the monitoring team, particularly regarding positioning, alignment, and technique. Specific strategies are needed to ensure effective oral hygiene, but also safety for those at risk for aspiration. Though other attempts were made, toothbrushing for only one individual was possible. This involved use of the Plak-Vac device and the plan was followed and the individual was well-aligned. Staff supporting individuals who used the suction toothbrush had received specific training related to that process. There was no evidence in the OT/PT assessments or in the PNMT assessments that toothbrushing was observed. This should be a key element of these evaluations as poor alignment or technique may contribute to increased oral bacteria as well as risk of aspiration due to poor head/neck alignment. Each of these may increase the occurrence of pneumonia and certainly inadequate oral care. There must be collaboration between the dental hygienists and therapy staff to identify these strategies. This must be followed by staff training with demonstration and return demonstration, as well as routine monitoring to ensure it is done properly.	

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		The majority of staff struggled to verbalize the rationale for the strategies in the plans and to answer questions related to individual health risks, but there were some others who demonstrated excellence with this. <u>Choking/Aspiration Events</u> There were 83 individuals identified at high risk for choking and 89 others considered to be at medium risk. There were seven choking incidents for six individuals reported by the facility during the last 12 months. Three of these had occurred since the previous review. This was obviously a decrease since the last six month period, but still was considered to be high incidence for a 12 month period. Two reportedly required the Heimlich (Individual #385 and Individual #314) and two were with individuals on their prescribed texture (Individual #137 and Individual #314). The third incident for Individual #385 was related to food stealing of an item not on her prescribed diet order (flour tortilla). This was more likely pertaining to a supervision issue, rather than a problem with the design or implementation of the dining plan, though each of these would require assessment by an OT and/or SLP at the next meal following the incident. Individual #137 was included in the sample selected by the monitoring team and documentation related to this incident was reviewed. The event occurred at the evening meal and required three thrusts to clear. Her diet order was reduced from chopped to pureed. She was observed and assessed by the SLP at the noon meal the next day and deemed to continue to be safe on the original chopped diet and thin liquids, but continued to require staff cueing to take small bites and eat a safe pace. She was assigned 1:1 staff supervision when she was out of bed, including meals. An ISPA was held the next day and changes to her PNMP/dining plan were established. It was noted that her diet order was reported in the ISPA to have been changed to ground rather than pureed, though it was agreed that she should return to chopped. Other than the timeliness of the SLP evaluation, the follow-up to this event appeared to be appropriate. It would be preferred, however, that the assessment occur at the next meal to ensure that assessment of all issues related to the mealtime were identified. With the diet order change only, there could be other concerns that contributed to the event that would not be effectively addressed by merely downgrading the diet. Some facilities have developed an on-call system to address these emergencies and others have instituted an interim observation by nursing to determine whether an OT/SLP assessment could be delayed, though should never take place more than 24 hours after the original event. This issue is of particular concern for incidents that may occur late on Fridays or over the weekend. There were 19 individuals with food texture or liquid consistency downgrades in the last year (1/5/12 to 12/14/12). Overall, there were approximately 98 individuals on	

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		modified diets and/or thickened liquids. While these modifications are often indicated for individuals with dysphagia to protect and minimize their risk of choking and aspiration, this strategy should not be used exclusively in the absence of staff supervision and assistance techniques as well as skill acquisition training for individuals who display impulsivity with rapid eating and drinking or large bites.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>New Employee Orientation</u> The NEO training included 16 hours dedicated to lifting, transfers, handling, positioning and dysphagia/mealtime content. A third day involved on-home training. Training scripts, handouts and check-offs were submitted. By report, the content was currently under review with revisions planned and a new policy was to be drafted regarding training. At the time of this review, the PNMPCs conducted this training, though participation by the therapy assistants was planned in the near future. Phase One training took place in the classroom and involved demonstration and practice with a check-off for return demonstration or a written test. Phase Two training involved the NEO shadowing process also currently being revised. This was a home-based training and included a check-off of foundational skills completed in the home environment with individuals. Shadowing was assigned after completion of the NEO classes and staff received home-specific/individual specific training (up to four hours per employee) conducted by the PNMPCs with up to 15 days to complete this in the following homes: 509B, 508A, 510A, 512A, 511A East and 511A West and 516East and West. These homes were residences for individuals with more complex PNM needs. Non-foundational skills (person-specific supports) were also provided during NEO shadowing, included training and a skill check-off using training packets for each participant. For other homes, the PNMPCs reviewed the PNMPs, but did not provide increased training beyond that provided in NEO. Each employee was provided a "toolkit" that consisted of cards outlining key information for each area for which training was provided. Employees were also expected to sign an acknowledgement that they had been trained to implement the PNMP as written, 24 hours a day, seven days a week. Check-offs were completed in each area (Skills Drills for Positioning, Off Home supports, Mealtime, AAC, Lifting and Transfers), permitting up to 30 days to establish this. This was repeated until the staff achieved competency or an action plan was developed by the Home Manager to address training issues. No staff was permitted to assist individuals alone until competency was demonstrated. A Home Reference Guide had been developed and distributed for new employees. Compliance monitoring then continued and in the case that a DSP had two noncompliant skill drills in one six month period, he or she would be referred back to the Competency Training and Development department to re-establish competency through additional lectures, practice, and check-offs. Phase Three training involved the annual refresher with a classroom check-off and again also on the home. Annual retraining included lifting and transfers only. An iLearn class	Noncompliance

#	Provision	Assessment of Status	Compliance
		related to aspiration was also provided annually to staff. NEO training was generally audited every six months though, by report, not all PNMP coordinators were monitored routinely. They had original been trained and completed a competency check-off to conduct the training and associated check-offs for NEO staff. Routine audits of all trainers should be considered to ensure that the content and check-offs process remained accurate and consistent across time and trainers. <u>Individual-Specific PNMP Training</u> Initial inservice training for new changes in the Dining Plans and PNMPs (new foundational and non-foundational skills) were conducted by therapists for as many staff as possible. The PNMPCs also participated and then conducted cascade training for any additional staff. Training as required for existing plans was completed by the PNMPCs. A general inservice was completed and staff signed the training record as a participant, but it was not clear as to how competence was documented based on the training records for dining plans submitted. Compliance monitoring was conducted, but in some cases this was done a month later and did not constitute adequate competency-based training. Attachments to the training signature sheets included the plan and listed specific training content. Ongoing compliance monitoring should follow to ensure that staff retain competency in the implementation of both foundational and non-foundational skills and this was done consistently, but drive by risk level of individuals and not specifically per staff. In other words, some staff may not receive compliance monitoring at any routine interval until the annual refresher. For those at highest risk, it would be important to ensure that this monitoring was done for all staff assigned to those individuals rather than only whoever was assigned at the time the monitoring was completed. In the case that a PNMPC or home manager was expected to conduct further staff training, they had signed the training record though again it was not clear if this was competency (with return demonstration) in implementation of the plan and competency in training staff. It is important that staff not work with an individual at high risk until they are trained and checked off. Pulled staff should receive this training by supervisors, managers, and/or habilitation therapies as necessary. Training for pulled staff should not be limited to merely reading the plans. There did not appear to be a clear protocol related to ensuring that training for pulled staff was provided in a timely manner. Some of the staff observed by the monitoring team were pulled staff and most were not able to state that they had received specific training related to the individuals to whom they were assigned regarding PNM supports and risk issues.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td><u>Trainer Competencies</u>
Assignments for the PNMPCs were undergoing some changes to be initiated after this monitoring visit. Preparation and training for their assigned roles will be further reviewed during the next onsite visit.</td><td></td></tr>
<tr><td>O6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.</td><td><u>Individual-Specific Monitoring</u>
The current monitoring system for implementation compliance and staff competency was based on individual risk levels. While this type of monitoring focused on staff performance, it was tracked per individual rather than per staff. As such, it was not possible to ensure that all staff were monitored for continued and consistent compliance. (This is different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function, and risk levels and that should be a key element in an effective PNM system.)

The list of individuals for whom PNM monitoring had been completed in the last quarter was requested and submitted. These lists identified the monitoring conducted per individual across various areas of the PNMP. A total of 574 monitorings were completed in September 2012 (194), August 2012 (200) and July 2012 (180). The type of monitoring was not reported on this list.

The monitoring team requested monitoring forms completed in the last month. There were 163 Compliance Monitoring forms submitted. None of these was marked as a reliability check. In 11 cases, compliance ratings were marked.

The forms were not culled for duplications due to the number submitted. Monitoring was completed as follows:

<table>
<tr><th>PNMP Area</th><th>Number</th><th>% of Total</th></tr>
<tr><td>Communication</td><td>2</td><td>1%</td></tr>
<tr><td>Off-home</td><td>3</td><td>2%</td></tr>
<tr><td>Meal/Snack</td><td>37</td><td>23%</td></tr>
<tr><td>Positioning</td><td>29</td><td>18%</td></tr>
<tr><td>Positioning- Oral care</td><td>16</td><td>10%</td></tr>
<tr><td>Positioning- Medication Administration</td><td>22</td><td>13%</td></tr>
<tr><td>Positioning- Enteral Nutrition</td><td>1</td><td><1%</td></tr>
<tr><td>Lifting/Transfers</td><td>11</td><td>7%</td></tr>
<tr><td>Equipment</td><td>42</td><td>26%</td></tr>
</table>

• There was no monitoring conducted on third shift.
• 38 forms (23%) were marked as completed after 2:00 pm (second shift) and at</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		least 10 of these were completed after 5:00 pm. • 6 forms were did not designate a time. • 45 forms were completed between 12 noon and before 2:00 pm. • 74 forms were completed between 6:00 am and before 12 noon. • 26 forms were completed prior to 8:00 am. Compliance scores: 100% | 90% | 80% | 70% | 60% | No score 137 | 8 | 10 | 5 | 2 | 1 Risk Levels: • High risk (102) • Medium risk (61) Based on these data, it appeared that over half of the monitoring was focused on mealtimes and equipment only. Very little monitoring of communication was conducted. While positioning was consistently monitored, transfers/lifting was not. There was relative consistency across meals, though 73% of monitoring occurred on first shift. If the facility truly intends to examine staff compliance and effectiveness of supports throughout the day, monitoring must be reflected across the times the supports are provided and not focused during the times that are the most convenient for professional staff and the PNMPCs. Note that the most significant issues identified by the monitoring team were observed on the second shift during the evening meal. Compliance scores were high, with at least 84% of compliance scores at 100%, and 95% above 80%. This did not accurately reflect what was observed routinely through other means. The director clearly recognized this concern and had plans to further address this issue. While equipment was monitored by the PNMPCs using the Compliance Monitoring Form, there should be a proactive system to conduct quarterly reviews of the condition of equipment. This was typically conducted during quarterly or in some cases semi-annual reviews by the therapy staff in PNM Clinic in conjunction with wheelchair shop staff. At that time, fit and maintenance issues were identified and in many cases resolved on the spot. A Maintenance Log was maintained to track these and other maintenance needs as they arose in the interim.	

#	Provision	Assessment of Status	Compliance
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Effectiveness Monitoring</u> A system of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff was to be conducted quarterly. A special form had been created for this purpose and included compliance monitoring as described above, typically completed by the PNMPCs. In addition, a health status review was reported related to specific key PNM indicators, including the date and interventions. The therapist was to determine if the individual had made progress, regressed, or maintained his or her health and functional status. Further analysis identified additional areas of concern and whether these had been previously identified. The plan was deemed to be effective or if ineffective, what specifically was problematic. Actions needed were outlined with the results documented in the IPN. At least 70 of these were submitted as completed in September, October, and November 2012. Overall effectiveness was reported to be 85% on average. While above 80% compliance was acceptable for many aspects of the PNM support system, it would be expected that actual effectiveness of these plans should be held to a higher standard under review. Analysis of the issues contributing to ineffectiveness should be conducted. In addition, while the format appeared to be very good, the implementation did not appear to be consistent (less than 50% completion, 70 of 147 PNMPs) given that individuals with PNMPs would each require this type of review on a quarterly basis. There were 200 individuals identified with needs and at least 147 individuals were provided a PNMP. In many cases, the effectiveness of interventions and supports were not consistently and specifically addressed in the annual assessments, though the new format required this and this was expected to improve. This should be a key function of the professional staff clinicians. These forms will assist the clinicians in reporting and utilizing this information in ISPs, ISPAs, and PNMT meetings. Effectiveness monitoring and additional staff training was indicated related to implementation of programs across all environments and not only in the home. <u>Validation of Monitoring by PNMPCs</u> The facility reported a lack of confidence in the findings of monitoring conducted by the PNMPCs and, as such, was planning to revise the system. This will be a focus of review in the next six months. <u>Trend Analysis</u> Tracking and trending was conducted, but as described above the results were not believed to be valid at this time.	Noncompliance

#	Provision	Assessment of Status	Compliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Individuals Who Received Enteral Nutrition</u> There were nine individuals who received enteral nutrition (4%). None were listed as having received a new tube placement since the previous review. Each was identified as NPO (nothing by mouth). Two individuals who received enteral nutrition were also listed to have poor oral hygiene during 2012. Poor oral hygiene promotes bacterial growth and the risk of aspiration pneumonia would be increased for those individuals, likely with tubes secondary to aspiration risk, though neither were listed with pneumonia in the last year. The list that identified individuals with pneumonia in the last 12 months included 34 incidences for 27 individuals from 9/7/11 to 9/26/12. Six were identified with aspiration pneumonia (Individual #128, Individual #146, Individual #59, Individual #76, Individual #26, and Individual #150) two with viral and the other cases were categorized as bacterial pneumonia. Individual #203 was listed with aspiration, but no pneumonia on 1/24/12. Five of the individuals, including Individual #203, received enteral nutrition and the others were reported to eat orally (also Individual #278, Individual #128, Individual #90, and Individual #98). Five individuals had more than one incidence of pneumonia, (Individual #278, Individual #150, Individual #76, Individual #363, and Individual #78). Individual #278 and Individual #78 were listed with pneumonia on three occasions, each described as bacterial. The 26 cases of bacterial pneumonia should not be ruled out as aspiration-related because bacterial pneumonia may be secondary to bacteria present in the oral and pharyngeal areas, as is often the case for individuals with poor oral hygiene. None of these were listed with poor oral hygiene, however. A committee had recently been established to review all cases of pneumonia to determine if the clinical indicators were suggestive of aspiration pneumonia. This process was observed by the monitoring team and the discussion was in depth, though there was some inaccuracy in the information presented. This process will evolve and the monitoring team will conduct further review in six months. Individual #278 and Individual #66 had existing enteral tube placements and were listed with BMIs that placed them in the underweight category though neither was identified with an unplanned weight loss. Enteral nutrition permits a prescribed intake and weight loss of this nature may suggest other health issues or that the intake provided was less than prescribed. APEN Evaluations completed in the last six months were requested by the monitoring team. There were six APEN assessments submitted for review as follows: • Individual #278: 3/23/11, 5/1/11	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #146: 3/22/12 • Individual #98: 1/21/11 • Individual #203: 8/24/12 • Individual #90: 3/24/11 Per policy, these were to be completed for individuals with aspiration pneumonia and/or annually for individuals who received enteral nutrition. Only two of these had been completed in the last year and only one was current within the last six months. Each of the other three was past due for the annual APEN evaluation. Individual #150 had experienced aspiration pneumonia on 9/26/12 and there was no evidence that this evaluation had been completed for him. Upon review of the APEN evaluation for Individual #203, it was noted to be complete and presented a clear rationale of why she received enteral nutrition and previous, albeit unsuccessful efforts, to maintain oral intake. There was a measurable outcome established that she would have decreased episodes of formula in her mouth to less than one a month to none though proper alignment and positioning. Unfortunately, there was no baseline for this outcome. Further the team determined that a new action plan was not needed for this. This may have been appropriate, but a baseline was needed, and a method to track this occurrence, including her position, was indicated. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that included the same elements as described above.	

Recommendations:

1. Continue to provide training and support to the IDTs for consistency and timeliness of appropriate referrals to the PNMT (O1, O2).
2. Consistently document completion of actions and recommendations to close the loop on identified needs (O2).
3. Review specific measurable exit criteria established in the assessment and include these routinely in PNMT documentation. These should pertain to the reason for referral, but also other issues identified as a function of the comprehensive assessment (O2).
4. The IDTs should utilize referral criteria and other measurable outcomes developed by the PNMT for improved consistency of referral of individuals in a timely manner (O2, O3).

5. Centralize database of key health clinical indicators to ensure it is current and accurate. This should be a facility-side project that includes key staff. This information should be updated routinely. These may be used by the PNMT to track individuals who meet certain thresholds for health issues that would indicate a need for referral (O2).

6. Focus staff training and monitoring throughout the day to include day programs, work settings and the homes, particularly on 2nd shift (O3, O5, O6).

7. Consider including the following in the PNMT evaluation: timeframe of medical history (such as last 12 months, for example), doses, schedule and start dates of medications, review of drug-nutrient interactions, presentation of any actual drug interactions, more complete nutrition assessment, reorganization of content to limit analysis and recommendation statements to the end of the report to avoid losing key information (O2).

8. PNMPs require better integration into the ISP via descriptions of PNM strategies and clear evidence of review of these and their effectiveness relative to risk levels (O3).

9. Address chaos and confusion in the preparation areas of the dining rooms to ensure efficiency, accuracy, and safety (O3, O4, and O5).

10. Address toothbrushing via actual observations in the PNMT evaluations and OT/PT evaluations (O2, O3, and O4)

11. Clarify the existing system of compliance and effectiveness monitoring including the role of therapists and PNMPCs (O6, O7).

12. Improve the consistency of completion of effectiveness monitoring (O7)

13. Clarify the purpose and process for completion of the APENs. These have been typically incomplete and without clear purpose in the existing format at many facilities. Perhaps this should be a function of the ISP process. Integration into that document may be more meaningful and useful (O8).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SGSSLC client list o Admissions list o Staff list and Curriculum Vitae o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical Nutritional Management o Section O and P QA Reports o OT/PT Tracking Logs (Equipment, Assessment Tracking, Audits, Program Effectiveness, Compliance Tracking) o PNM Draft Policy (9/14/12) o Habilitation Therapy Assessment Procedure (Draft o Dental Care – Suction Toothbrush policy (Revised 5/24/12) o Protocols Related to Choking Incidents/Abdominal Thrusts/Coughing Episodes (Revised 6/28/12) o Integrated Clinical Services and Minimum Common Elements of Clinical Care (9/13/12) o Daily Provider Meeting minutes submitted o Skin Integrity Team minutes o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring template o Effectiveness Monitoring Tool template o Completed Compliance Monitoring sheets submitted o Completed Effectiveness Monitoring tools submitted o Completed Compliance Monitoring sheets submitted o Completed Effectiveness Monitoring tools submitted o Habilitation Therapy ISP Essential Elements Checklist o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months (10/17/12)

	o Individuals with Pain o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 12 Months o Non-Injury Falls (10/1/11 – 10/16/12) o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans) o PNMPs and sample picture pages submitted o PNM Maintenance Log o Wheelchair evaluations submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment log o Sample OT/PT Assessments with Audits submitted o OT/PT Assessments for individuals recently admitted to SGSSLC: Individual #207, Individual #370, Individual #220, Individual #35, and Individual #267. o OT/PT Assessments and ISPs for the following individuals: • Individual #294, Individual #39, Individual #353, Individual #250, Individual #189, Individual #69, Individual #130. o OT/PT Assessments, ISPs, ISPAs, and other related documentation for the following individuals: • Individual #145, Individual #78, Individual #71, and Individual #271. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140,

	Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. o PNMP section in Individual Notebooks for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Judy Perkins, PT o Cindy Bolen, PT o Jessica Krotzer, PTA o Charis Worden, OTR o Brandon Fox, COTA o Various supervisors and direct support staff o PT treatment sessions for Individual #140 and Individual #318 o ISP Meeting for Individual #127 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas o OT/PT Treatment Rooms <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas

	Facility Self-Assessment: In the self-assessment, Dena Johnston, OTR, the Rehabilitation Therapies Director, outlined specific self-assessment activities and provided specific data based on the findings from these activities. The activities were similar to the process used by the monitoring team, and included many of the same or similar key elements used for review and outlined in this report. She continued to demonstrate significant understanding of this process and this likely drove the success and progress they experienced with this provision over the last six months. P1 was found to continue to be in substantial compliance by the monitoring team and this was supported in the self-assessment for this section as well. Each of the clinicians currently providing services appeared to be exceptional. The addition of therapy assistants will be key to the clinicians' ability to complete assessments, improve attendance at ISPs, provide necessary direct therapy services, and provide support for skill acquisition plans. The work environment in the department appeared to be positive as evidenced by the retention of long-term employees. P2 through P4 were found to be incompliance by the monitoring team as outlined below. This was consistent with the findings by the facility. Excellent progress, however, was made in each of these and the measures of success will ensure continued movement toward substantial compliance. The data reported were relevant to each of the provision items and were logically presented. This allowed the department to readily track their own progress and compare their findings with that of the monitoring team. The director's approach to this process continues to be refined and improved with each round of monitoring. The action plans developed were on point and will likely assist the department in moving toward substantial compliance. The majority of actions had been completed. This, plus strong leadership, were likely significant factors in the consistent progress made, despite the limitations of staffing.
	Summary of Monitor's Assessment: The monitoring team noted continued progress with this provision. Staffing continued to be a concern, and as a result, therapists had to make choices between participating in ISPs and ISPAs or completing assessments and updates in a timely manner for the IDTs to have for these ISPs. The clinicians had difficulty routinely attending meetings and, in some cases, IDTs had to table discussions or send action referrals for supports or further information. This only delayed the provision of key supports and services identified as needed by individuals. The use of ISPAs to integrate additional supports and services was not consistent. A system of assessment audits successfully shaped the consistency of content in the assessments and updates completed by the therapists. The need for updates was not clear in the recommendations. Frequency of monitoring was not addressed as a recommendation, but rather documented in various sections throughout the assessment and, as such, would be difficult for IDTs to locate and use. The findings over the year were not reported consistently, though there had been a noted improvement in the more recent assessments reviewed.

	Routine effectiveness monitoring was conducted by the clinicians. Staff compliance monitoring by the PNMPCs was deemed to be inaccurate. Both should be implemented in a manner that is thoughtful, meaningful, and accurate. Therapists need to routinely observe the implementation of strategies and ensure that staff are able to correctly integrate supports throughout the day. The therapists need to continue to expand the time they spend in the day program areas to address integration so they can model, coach, and support staff and individuals in the homes, day programs and work settings. This will require adequate staffing and time management.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>Current Staffing</u> Dena Johnston, OTR, continued to serve as the Director of Habilitation Therapies. OT/PT staffing was increased slightly since the previous review. There continued to be two physical therapists, Cindy Bolen, PT (full-time state employee), and Judy Perkins, PT (full-time state employee), and a new contract PTA Jessica Krotzer (start date was 10/17/12). The only staff occupational therapist continued to be Charis Worden, OTR, and a new contract COTA, Brandon Fox (start date was 11/5/12). Six of six (100%) therapy clinicians were verified with current licenses to practice in the State of Texas. Per the documentation submitted for section I, there were three budgeted positions for OT with one vacancy and two budgeted positions for PT with one vacancy. It appeared that there was an error in reporting the FTEs and caseload ratios for these (the numbers appeared to be reversed for OT and PT). There were two vacancies for OT and none for PT. The caseloads were reportedly based on the number of PNMPs and direct services, calculated at 1:78 for PT and 1 for 156 for OT. Of course, in the case of a change in status, acute care services may be indicated for those without a PNMP at any given time. Ms. Johnston served as the PNMT OTR. Ms. Perkins served as the PNMT PT and, as such, her active caseload responsibilities were greater than 78. Caseloads for the assistants had not been determined and were evolving at the time of this onsite review. The census at SGSSLC was 223 individuals and 200 were listed with PNM. Thus, the majority of individuals were identified with PNM needs. It was not clear how the facility calculated any of the ratios reported above, but based on the current staffing and census, actual service ratios for the entire census were 1:112 for PT and 1:100 when considering only those listed with PNM needs. The OT ratio was 1:223 for the entire census and 1:200 for those listed with PNM needs. The monitoring team calculated ratios based on the OTs and PTs only and did not include assistants because they were not licensed to conduct assessments, required supervision, and could not independently design programs and interventions. They were, however, extremely valuable members of the team because	Substantial Compliance

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		they extended the therapeutic contact with individuals, and provided interventions, staff training and monitoring. These ratios were very high and impacted the clinicians' ability to provide comprehensive supports and services. Based on the documentation submitted: • There were 28 individuals listed as seated in wheelchairs as their primary means of mobility and another 15 who required wheelchairs for transportation. • Approximately 23 individuals required assistive devices for ambulation, such as gait belts, walkers, and canes for safety while ambulating, 11 of whom were also listed as requiring transport wheelchairs, likely for long distances. • Approximately 26 individuals were listed as requiring assisted ambulation and 22 were listed as non-ambulatory. • Over 56 individuals had orthotics or braces. Another 21 individuals required custom or orthopedic shoes. One individual required a neck brace (Individual #127). <u>Continuing Education</u> A CEU tracking sheet was developed to permit the director to accurately report continuing education attended by the OT/PT clinicians throughout the year. Per this tracking log, five of five clinicians attended continuing education in the last 12 months. Topic areas included: • PNMT training (5.5 hours) • Annual Habilitation Therapies Conference (13.5 hours) • Individuals with Developmental Disabilities (11 hours) • Autism, Asperger's, SPD, and ADHD (6 hours) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (17.5 hours) • Food Additions, Overeating and Mood Swings (6 hours) • Stroke Recovery (6 hours) Most of these were state-sponsored courses, though three of the four clinicians had attended additional education opportunities. This was adequate participation for each clinician. It continued to be important that all clinicians be encouraged to attend annual educational opportunities beyond just those offered by the state to ensure that they continue to expand their knowledge and skills. Participation in ongoing continuing education is critical and should be encouraged throughout the year for all clinicians, including the contract therapists. <u>New Admissions</u> Fourteen individuals were admitted to the facility since the last onsite review. Samples of new admission assessments completed since the previous review were requested and five were submitted (Individual #207, Individual #35, Individual #370, Individual #220, and	

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		Individual #267). Individual #207 was not included on the list of new admissions or the current census list so the admission date could not be determined. Each of the other assessments was completed within 30 days of admission and at least five days prior to the ISP date reported on the assessment. A system of screenings was planned, though not initiated at the time of this onsite review. A draft policy Habilitation Therapy Assessment Procedure indicated that the screening would be completed for individuals newly admitted to the facility and completed five days prior to the ISP. If therapy needs were not identified, a screening would be repeated every five years. If needs were identified, a comprehensive assessment would be completed within 30 days. For individuals who were provided direct and/or indirect services, a Comprehensive Assessment would be completed every five years with an Assessment of Current Status annually in the interim. The screening should include what factors were reviewed, as well as a statement that no further assessment was indicated, or that a comprehensive assessment was needed and the projected date of completion. The screening should also indicate the frequency of subsequent review, if indicated and a reference for the IDT to make a referral in the case of a change in functional status. These screenings should not be purged from the individual record until a subsequent screening or evaluation was completed. Overall, this was a reasonable plan. <u>OT/PT Assessments</u> The draft OT/PT assessment template instructions indicated that the assessment should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. This draft included content guidelines for use by the clinicians in the development of their reports. Per the guidelines, the comprehensive assessment was to be completed within 29 days of admission and an update was to be completed at least annually regarding services provided during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment with rationale was to be included in the written report. The content guidelines for each of these areas were extensive and comprehensive in nature. The five most current assessments for each clinician (15), new admission assessments (5), and the OT/PT assessments for 21 individuals in the sample selected by the monitoring team were submitted. Only the five most current assessments for each PT were selected because the OT, Charis Worden, had participated in all 15 assessments. A variety of assessments were submitted, though only the most current was listed below: • 15 were identified as OT/PT Comprehensive Evaluations. Each of these was current within the last 12 months.	

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		• 5 were identified as Rehabilitation Therapy Comprehensive Evaluations. Each was current within the last 12 months. • 1 was identified as an Occupational Therapy/Physical Therapy Assessment. It was current within this last 12 months (Individual #352), though did not contain the same elements as the comprehensive assessments. • 2 were identified as Rehab Assessments. Each of these was described as an update for a previous comprehensive assessment, though they were not titled as such. The assessment referenced for Individual #251 was also in his individual record, but the assessment referenced for Individual #77 was not (7/13/11). The most current previous assessments were completed in 2007 and 2009. • 1 was identified as a Rehabilitation Therapy Assessment. This assessment, dated 3/3/11 for Individual #21, was not current within the last 12 months. There was no evidence of an update in his individual record, though one was indicated due to his PNM needs. • 10 were identified as Evaluation Updates. Eight of these were current within the last 12 months, though the update for Individual #76 expired the week of this review. Though each of these referenced a previous comprehensive assessment, none were contained within their individual records. In the case of Individual #76, the comprehensive assessment referenced (12/10/10) was actually an update. The previous evaluation was dated 11/14/07. In the case of Individual #137, the update on 12/14/11 referenced a comprehensive assessment completed on 12/3/10, however, this was actually an update and there was no evidence of a comprehensive assessment in her individual record. In the cases of Individual #150, Individual #112, and Individual #85, the assessments referenced in the update were not comprehensive. There was no evidence of comprehensive assessments or subsequent updates for Individual #34, Individual #40, and Individual #178, though they were referenced in the updates submitted. Only the updates for Individual #34 and Individual #40 were current within the last 12 months. All in all, there were 19 comprehensive assessments included in the analysis by the monitoring team and only one update (Individual #251). The update included the required elements, but there was no statement that the information in the comprehensive assessment remained accurate. There was no update as to the health status over the last year, though it was discussed in the analysis section. Only three risk areas were reviewed. Most of the updates were not submitted with the associated comprehensive assessments. Others were submitted with assessments not considered to be comprehensive or were not current within the last 12 months (Individual #137, Individual #85, Individual #59, Individual #112, Individual #150, Individual #77, and Individual #76, for example).	

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		Findings related to the assessments were as follows: • 0 of 19 (0%) individuals had comprehensive assessments that contained each of the 24 elements outlined below. The percentage of assessments (19) that contained each element are listed below: • Signed and dated by the clinician upon completion of the written report (79%). All were signed, but some of the signatures were undated. • Dated as completed 10 days prior to the annual ISP (42%). The state required these to be completed 10 working days prior to the ISP per the ISP meeting guide. • Diagnoses and relevance to functional status (100%). This element was well done in all the assessments reviewed • Individual preferences, strengths, interests, likes, and dislikes were described (100%). • Medical history and relevance to functional status (84%). • Health status over the last year (53%). • Medications and potential side effects relevant to functional status (95%). • Documentation of how the individual's risk levels impact performance of functional skills (95%). It would be important to address all areas of risk relevant to PNM to determine if the current ratings were accurate and if changes were necessary based on findings and to ensure supports and services sufficiently addressed these needs. The approach to this section was very inconsistent. • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day (100%). The quality of this element was excellent. The more functional the description, the more useful the information would be to the team for programming in other areas. • Description of the current seating system for those requiring a wheelchair with a rationale for each component and need for changes to the system outlined as indicated (100%). • Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work) (84%). • Evidence of discussion of the PNMP as well as the effectiveness of the current version of the plan with necessary changes as required for individuals with PNM needs (95%). • Discussion of the expansion of the individual's current abilities (88%). • Discussion of the individual's potential to develop new functional skills (57%). • Comparative analysis of health and impact on functional status over the last year (84%). This should be addressed in the clinical analysis of findings. • Comparative analysis of current functional motor and activities of daily living skills with previous assessments (100%). This should be addressed in the clinical analysis of findings.	

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		• Addressed the individual's foundational PNM and functional skill needs including clear clinical justification and rationale (100%). The analyses were significantly improved in all the assessments reviewed. • Identify need for direct or indirect OT and/or PT services (100%). This was generally more implied than stated. For example, the recommendations generally identified the need for indirect supports, but did not always state that the individual did not need direct OT or PT. • Reassessment schedule (100%). • Monitoring schedule 47%). The frequency of PNMP monitoring or effectiveness monitoring was not outlined consistently and in some cases, this was in various sections of the report. In order to ensure that the IDT can most effectively identify this, a separate section for this schedule would be best. • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs (77%). • Factors for community placement (100%). • Recommendations for services and supports in the community (100%). This section was consistently excellent. • Manner in which strategies, interventions, and programs should be utilized throughout the day (100%). These elements were included in the assessment audit conducted by the department and likely contributed to the significant improvements noted since the previous review. Additional findings: • There were 24 comprehensive assessments completed since the last review, per the tracking log submitted. This log did not track completion dates relative to the ISP. There were 29 updates completed, per this log. Only 12 were updates completed in 2011. Others were updates to assessments that were not likely comprehensive per the Settlement Agreement and seven of these had been completed more than four years ago. As none were identified as not requiring PNM supports, it would be expected that they would be provided a current comprehensive assessment rather than an update to a very outdated assessment. • 5% of the assessments contained 50 to 59% of the 24 minimum elements. • 0% of the assessments contained 60 to 69% of the 24 minimum elements. • 16% of the assessments contained 70% to 79% of the 24 minimum elements. • 42% of the assessments contained 80% to 89% of the 24 minimum elements. • 37% of the assessments contained 90% to 99% of the 24 minimum elements. • 79% of the assessments contained 80% or more of the 24 minimum elements. ISPs were also requested for each individual, except those who were newly admitted.	

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		Thirty were submitted, though seven were not current within the last 12 months. No ISP was submitted for Individual #251. Of those current ISPs submitted, five assessments submitted were completed 10 days prior to the ISP date identified in the assessment. In a number of cases, the report date did not correspond to the date of signature and, as such, were considered to be completed after the ISP (Individual #222, Individual #34, Individual #137, Individual #59, and Individual #128). Two were completed more than 45 days prior to the ISP and, in these cases, an update would be required (Individual #66 and Individual #40). There were six completed after the ISP and five with no current assessment associated with the ISPs submitted. A Habilitation Therapy ISP Essential Elements Checklist had been developed to guide the clinicians in ensuring that key elements were discussed and reviewed by the IDT. This should serve as a critical guide to the QDDPs to include the ISP requirements related to OT and PT supports and services. Review of the finalized ISP document would also be important to ensure accuracy. This provision was found to be in compliance in the previous review by the monitoring team. SGSSLC self-rated continued substantial compliance, and based on the above findings, the monitoring team concurred. The number of therapists, however, was not adequate, as evidenced by ISP attendance and completion of assessments after the ISP. Further, assessment completion averaged only 23%, but the total completed each month had increased steadily. All of the assessments for individuals newly admitted were completed and those reviewed were completed prior to the ISP. There was also a clear plan for completion of comprehensive assessments and updates and the quality of the assessments reviewed was above average with 79% of the assessments presenting with over 80% of the essential elements outlined above. The establishment of clinical competence of the therapists and review of their continued compliance was accomplished via an audit system that appeared to be very effective. The facility is cautioned, however, to assertively address the timely completion of assessments and consistent ISP attendance in order to sustain substantial compliance.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the	<u>Direct OT/PT Interventions</u> There were 16 individuals listed as receiving interventions provided beyond the PNMPs, including treatments and programs implemented by OT or PT. Thirteen were listed as PT and three were listed as OT. A sample of six was reviewed by the monitoring team (Individual #71, Individual #318, Individual #145, Individual #78, Individual #177, and Individual #271): • Current OT/PT assessment identified the need for intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • There were measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding	Noncompliance

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	individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the intervention plan related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Findings for the interventions provided to these six individuals included: • None of these interventions were integrated in the annual ISP. There was no evidence of an ISPA for the integration of these interventions into the ISP (Individual #177, Individual #145, and Individual #78). • There were current OT/PT assessments for Individual #318, Individual #78, and Individual #145 only. It was noted that for the other cases, an issue specific assessment was completed and documented in the IPNs (Individual #177, Individual #78, and Individual #71). • A new treatment note was implemented for filing in the individual record behind the Habilitation Therapies tab (Individual #78 and Individual #318). This should assist with meeting the basic documentation standards, however: o In the case that a PTA provides the intervention, a monthly summary should be provided by the supervising therapist to ensure that the intervention was effective and that there was sufficient progress toward the established measurable outcomes. o This should be an IPN to ensure that all team members were apprised of the status and progress of the therapy intervention. o While this was reported as completed by OT for Individual #78 on 11/30/12, there was no evidence of the written report. • While some had measurable objectives associated with the intervention (OT for Individual #78), reference to progress with these was not consistently noted in the documentation (Individual #78 and Individual #318). Others only had general outcomes statements (PT for Individual #78 and Individual #318) or none at all (Individual #177). • Five of the six individuals reviewed regarding their direct OT/PT services had a PNMP. Based on review of their ISPs, there was no evidence of actual review by the IDT regarding specific supports, effectiveness, consistency, and accuracy of implementation as per the monitoring results (Individual #145, Individual #78, Individual #318, and Individual #271). • OT/PT attendance at ISPs was noted for five of six individuals, but was	

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		inconsistent at ISPAs (Individual #177, Individual #145, Individual #78, Individual #318, Individual #71, and Individual #271). Documentation was inconsistent and did not effectively close the loop on direct services provided. For example, Individual #177: Her OT/PT evaluation (7/13/11) recommended Orthotics Clinic to evaluate for a softer version of orthotic to improve compliance. There was no evidence of an update completed prior to her ISP on 8/30/12 and neither OT nor PT was in attendance. She had at least nine falls as of 8/22/12 (ISPA). One of these resulted in a patellar fracture and head (required sutures) and tongue lacerations. A physician order for OT/PT referral was written per the addendum on 8/22/12, but there was no evidence that this was received, per the IPNs submitted. On 8/24/12, the PT noted that Individual #177 was seated in a wheelchair and then provided staff training related to transfers and weight bearing because staff reported that they were unaware that she was not to bear weight on her left leg. Other supports were provided and the PNMP was revised to reflect her revised needs. There was no further documentation until 9/18/12 by PT related to an issue-specific assessment per doctor's order. It was recommended that she see an orthopedist to determine when it would be safe for her to participate in direct PT. There was no further documentation until 10/2/12 when it was documented that PT was following up on her walking program. There was no documentation related to whether she saw an orthopedist, when the walking program was initiated, frequency and duration of intervention, or what the measurable outcomes were. She was to continue in PT until she was transitioned to the community. A discharge summary was written on 9/13/12, but there was no indication as to when she moved from the facility and when she was discharged from PT treatment. This could not be discerned from any of the documentation submitted. There were unexplained gaps in service without explanation, inconsistency in the provision of services and lack of rationale for discontinuing services. For example, a new admission assessment was completed for Individual #145 on 3/21/12, and then an IPN indicated that he was attending his second PT session on 4/30/12. There was no rationale for direct PT and no functional measurable goals outlined for this service. Frequency was to be three times a week, but documentation indicated that this was actually twice a month only. On 6/18/12 it was reported that he was not making progress and the PT would discuss this with the IDT when she was available to attend an ISPA. There was no evidence that this occurred. There was no documentation after 6/29/12 and no rationale for discharge from direct therapy. <u>Indirect Supports and Services</u> The primary OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O3 above regarding PNMP format and content. Implementation of PNMPs is addressed in section O5.	

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		Integration of OT/PT Supports and Services in the ISP Review of the ISPs submitted was as follows: • 77% (23 of 30) of the ISPs submitted were current within the last 12 months. ISPs were not requested for the new admission assessments. All of the current ISPs had attached signature sheets. • 4% (1 of 23) of the current ISPs with signature pages submitted were attended by both the PNMT OT and PT. • 52% (11 of 23) were attended by PT only. Two of these were attended by the PNMT PT only. • 13% (3 of 23) were attended by OT only. • 35% (8 of 23) of the current ISPs had no representation by an OT or PT This level of attendance was not acceptable and was a direct function of the low staffing level at the facility for OT and PT. As the clinicians worked very closely together, attendance by either OT or PT based on the identified needs as adequate representation would be provided by either in most cases. In the case that an individual was served by the PNMT, it would be expected that the IDT clinicians would also be present at these meetings unless they were the same (as may be the case only for Judy Perkins, PT). Participation by the IDT therapists would be indicated to ensure carry over and routine integration of supports and services. The self-assessment identified an inverse relationship between completion of assessments and attendance at ISP meetings. When attendance was up, completion of assessments was down, and vice versa. The new ISP process was evolving and required a significant time commitment from each team member to attend these very lengthy meetings. It would be anticipated (and hoped) that efficiency should improve as the teams become more familiar with the process. Likewise, as more comprehensive assessments are completed and interim updates (Assessment of Current Status) are completed annually, the time required to complete these would also decrease. A schedule to rotate the year that a comprehensive assessment was due across all individuals should be in place so that these will not all become due again in five years. That is likely the rationale for non-completion of some comprehensive assessments described in P1 above and would be an acceptable approach. Definite progress towards substantial compliance was noted for this provision item, but due to the inconsistencies in services and documentation, the monitoring team did not find it to be in substantial compliance. Proactive post-hospitalization assessments by the IDT therapy teams should be initiated to anticipate specific needs, rather than waiting for the IDT to send action referrals for supports. In addition, there was more of a focus on responding to problems identified by the IDT, rather than a focus also on new skill	

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		acquisition via SAPs. This is an important element of this provision and time spent throughout the daily routines of individuals, potentials and opportunities for this will be more readily recognized by the therapy clinicians. The therapists had been spending more time each week in the living areas to address integration. This needs to be expanded also to day programs so they can model, coach, and support staff and individuals in the homes, day programs and work settings. This will require adequate staffing and time management, however.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Competency-Based Training</u> Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs were addressed in detail in section O above.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>Monitoring</u> A system of monitoring of the PNMPs for staff compliance with the implementation of physical supports and the condition and availability of adaptive equipment was implemented at SGSSLC, though this was in the process of review and revision at the time of the onsite review. This was addressed in section O above. There was a system of routine effectiveness monitoring conducted by the clinicians. Recommended frequency of PNMP monitoring was not included in the OT/PT assessments in a consistent section to permit ease of reference for the IDT. Findings from either type of monitoring were not consistently reported. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment. The system of monitoring was undergoing revision because the data were believed to be unreliable and not representative of the observations of program implementation obtained from other systems. The PNMPC role was being evaluated and the monitoring looks forward to the system implemented over the next six months.	Noncompliance

Recommendations:

1. Continue to recruit experienced OT/PT clinicians to at least maintain or improve staffing ratios (P1).

2. Address conflicts related to ISP/ISPA attendance and timely completion of evaluations (P1, P2).

3. Ensure timely completion of updates for individuals provided supports and services. Ensure that associated assessments are not purged prematurely from the individual records (P1, P2).

4. Clearly establish baselines in the OT/PT assessments as the foundation for interventions and measurable, functional outcomes (P1 and P2).

5. Include measurable performance criteria in the objectives for interventions and refer to these in all documentation (P1 and P2).

6. Ensure that all OT/PT interventions are integrated into the ISPs/ISPAs and that there is consistent review of the PNMP by the IDT (P1, P2).

7. There was a continued need to develop programs to address increasing or expanding functional skills. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).

8. Results and findings from PNM monitoring and effectiveness monitoring during the last year should consistently be reviewed and summarized (P1).

9. Documentation of direct therapy services should state a clear rationale to initiate, continue the service, modify the plan, or discharge. Measurable goals should be clearly stated and integrated into the ISP. Data collected should link to the expected outcomes and progress notes should summarize progress. Close the loop (P2).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SGSSLC Policy: Dental Services, 9/15/11 o SGSSLC Comprehensive Provision of Dental Services Policy and Procedure, 12/3/12 o SGSSLC Policy: Missed Dental Appointments, 9/15/11 o SGSSLC Policy: Desensitization and Intervention Policy for Dental Services, 8/11/10 o SGSSLC Policy: Dental Care – Suction Toothbrush, 5/1/12 o SGSSLC Policy: Oral Care For Individuals With Dysphagia, 1/11/10 o SGSSLC Policy: New Employee Oral Care Training, 2/10/10 o SGSSLC Policy: Annual Examinations, 3/1/10 o SGSSLC Policy: Dental Appointment tracking, 3/5/10 o SGSSLC Policy: Emergency Dental Treatment, 2/23/10 o SGSSLC Policy and Procedure Pretreatment Sedation Notification and Referral for Assessment Process, 7/26/12 o SGSSLC Organizational Charts o SGSSLC Self -Assessment Section Q o SGSSLC Action Plan Section Q o SGSSLC Provision Action Plan o Presentation Book, Section Q o Systematic Desensitization Performance Improvement Team Meeting Minutes, 12/6/12 o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o Dental Records for the Individuals listed in Section L o Desensitization Plans for the following individuals: • Individual #225, Individual #18, Individual #203, Individual #236 o Annual Dental Assessments for the following individuals: • Individual #64, Individual #196, Individual #53 Individual #66, Individual #117, Individual #186, Individual #179, Individual #193, Individual #170, Individual #253 o Emergency Documentation for the following individuals: • Individual #338 o Annual Dental Summaries for the following individuals: • Individual #120, Individual #193, Individual #57, Individual #321, Individual #265, Individual #252, Individual #251, Individual #298, Individual #255, Individual #194, Individual #130, Individual #163, Individual #132, Individual #177, Individual #50,

	Individual #294, Individual #292, Individual #214 Interviews and Meetings Held: o William Todd Walker, DDS, Dental Director o Belinda Lendermon, RDH o Lisa Willingam, RDH o Andre Golden, Dental Assistant o Lisa Owen, RN, Quality Enhancement Nurse o Misty Mendez, Settlement Agreement Coordinator o Angela Kissko, QA Director Observations Conducted: o Dental Department o Dental Benchmark Meeting o Administrative IDT Meeting o Daily Medical Provider Meetings o Observation of treatment in clinic
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) provision action information. For each provision item, a numbered list of activities engaged in to conduct the self-assessment was provided. The results of each activity were listed. Based on the results, a self-rating was determined. Dental clinics statewide utilized a template for completion of the self-assessment. The activities engaged in examined many of the issues reviewed by the monitoring team. For Provision Q1, the assessment reviewed compliance with annual assessment, and initial exams. Oral hygiene ratings were reviewed as well as compliance with provision of hygiene instructions. To take this process forward, the monitoring team recommends that the center lead continue this type of self-assessment, but expand upon it by adding more items included in the review of the monitoring report. The facility found itself in noncompliance with both provision items. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: The dental clinic continued to have staffing changes. The new dental director began employment on 9/1/12 replacing the previous director whose tenure ended on 8/31/12. A part time contract dentist started on 8/1/12, which allowed the new director to transition into the clinic with only modest declines in the number of appointments. A new dental assistant was also hired on 6/1/12.

	The clinic made visible progress since the last compliance review. The dental director was very engaged in the processes and activities of the clinic and facility. He was very familiar with the Settlement Agreement, previous reports, and recommendations. He also was aware of the current status of the clinic and was quite eager to discuss the provisions and related data. Several changes were implemented since the last review. All individuals were essentially being comprehensively reassessed and treatment plans developed. One particular psychologist was reported to have become more involved in clinic, helping to assess the needs of individuals. The method for rating oral hygiene was changed to a more objective system and individuals with poor ratings were enrolled in a toothbrushing program. This program required weekly visits to clinic as well as a SAP. Employees continued to have oral care training in new employee orientation that was provided by the contract dentist. The compliance rate with annual assessment overall improved with the exception of October 2012. All but one individual received timely initial assessments. IPN documentation was now generated electronically resolving the legibility problems noted in previous reviews. The content of documents, such as the annual summaries also improved. Notwithstanding these many advances, the facility has considerable work to do with regards to removing barriers to treatment. The average failure rate was 22% with a refusal rate of 5%. However, the monitoring team had concerns about the accuracy of the refusal rate and the classification of failed appointments. Moreover, for those individuals who progressed to the stage of having a formal desensitization plan implemented, there was no evidence that the plans were adequately followed.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with the members of the clinic staff, medical staff, the medical compliance nurse, and the facility director. <u>Staffing</u> The dental clinic staff was comprised of a full time dental director, full time hygienist, and full time dental assistant. The part time dentist and part time hygienist both worked two days a week. The full time hygienist did not routinely provide any direct clinical care. She was essentially responsible for the overall operation of the clinic and programmatic issues. <u>Provision of Services</u> The clinic had two fully equipped operatories and provided basic dental services including prophylactic treatments, restorative procedures, such as resins and amalgams, extractions of non-restorable teeth, and x-rays. The total number of clinic visits and key category visits are summarized below.	Noncompliance

#	Provision	Assessment of Status	Compliance

Dental Clinic Appointments 2012							
	Apr	May	Jun	Jul	Aug	Sep	Oct
Preventive	61	59	175	92	95	68	20
Emergency	0	1	0	0	0	0	0
Extractions	0	0	0	5	14	0	0
Restorative	0	1	0	11	13	10	20
Total	82	198	225	185	227	140	168

The dental director was in the process of completing assessments on individuals to determine their status. The hygienist indicated that some outstanding treatment issues were identified. The facility maintained a contract with a dental anesthesiologist who had not provided services in nearly a year, but was scheduled to provide services in January 2013. It was reported that three clinic days in January 2013 had been allocated to provide care with TIVA. At the time of the review, the facility did not have any arrangements with any community providers, but staff indicated discussions with a local provider were ongoing.

Emergency Care

Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals could be referred to the local emergency department, if necessary. The facility's emergency policy referenced the Title XIX standard, but did not reflect the actual requirement to have a dentist on call. The policy gave no indication that the primary provider had any access to the facility dentist after hours. The policy should be revised to reflect the after hours support that is provided.

In order to evaluate the provision of emergency care, the IPNs, from start of emergency to closure, and a copy of the dental evaluation and treatment were requested. The records of Individual #338 were reviewed. The IPN entries were difficult to read, however, what was determined was that the individual was admitted to the facility in late May 2012 and was referred to the dental clinic by the medical director one day after admission. The dental director documented approximately 17 teeth and/or root tips that required extraction. The individual reported no discomfort during the examination and subsequently underwent a full mouth extraction.

Oral Surgery

The facility did not refer any individuals to outside providers since the last visit.

Oral Hygiene

Oral hygiene ratings were documented during annual exams and clinic visits. The table below summarizes the quarterly ratings.

#	Provision	Assessment of Status	Compliance
		<table><tr><td colspan="3">Oral Hygiene Ratings 2012</td></tr><tr><td></td><td>March – May</td><td>April - June</td></tr><tr><td>Good %</td><td>78</td><td>80</td></tr><tr><td>Fair %</td><td>17</td><td>11</td></tr><tr><td>Poor %</td><td>1</td><td>8</td></tr></table> The dental director explained that a new more objective system of rating oral hygiene was being used. Additional hygiene ratings were scheduled to be calculated at the end of the quarter, which ended in November 2012. Further review will be done after additional ratings are completed with the new system. There were 17 individuals with poor oral hygiene at the time of the compliance review. All of these individuals participated in the dental clinic's toothbrushing program. This program required weekly evaluation and toothbrushing in the dental clinic. A SAP related to toothbrushing and oral care was also required. Once the individual's hygiene rating improved, weekly clinic visits were discontinued. The habilitation department identified individuals who were at high risk for aspiration and would benefit from suction toothbrushing. At the time of the compliance review, 19 individuals received this treatment, which were provided by direct care professionals who underwent competency-based training. Individuals received treatment two times a day. The dental hygienist conducted regular auditing to ensure that treatments occurred as ordered. Notification was sent to the home managers and QDDPs if deficiencies in treatment were noted. <u>Staff Training</u> All new staff received competency-based training during new employee orientation. This training was provided by the contract dentist. An annual oral hygiene refresher was available online through iLearn.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform	<u>Policies and Procedures</u> The Comprehensive Provision of Dental Services Policy was revised on 12/3/12. The revision captured changes including the program implemented to address poor oral hygiene as well as the new process for completing oral hygiene ratings. <u>Annual/Comprehensive Assessments</u> In order to determine compliance with this requirement, a list of all annual/comprehensive assessments completed during the past six months, along with the date of previous annual assessment, was requested. Assessments completed by the end of the anniversary month were considered to be in compliance. The available data	Noncompliance

#	Provision	Assessment of Status	Compliance
	the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	were used to calculate compliance rates that are summarized below. Annual Assessments 2012 Apr May Jun Jul Aug Sep Oct Number of Exams 13 23 22 21 4 13 5 Compliant Exams 11 23 21 21 3 11 1 % Compliance 85 100 95 100 75 85 20 The overall compliance score was 80%. The comprehensive dental records for 10 individuals were reviewed. The following is a summary of information found in the their most recent comprehensive dental assessment: • 10 of 10 (100%) assessments included an entry on cooperation, behavioral issues, and the need for sedation/restraint use • 10 of 10 (100%) assessments had entries for oral hygiene, teeth and restorations, and periodontal conditions • 10 of 10 (100%) assessments included documentation of oral cancer screenings • 10 of 10 (100%) assessments included documentation that oral hygiene recommendations were provided to the individual and/or staff • 9 of 10 (90%) assessments documented the risk rating • 9 of 10 (90%) assessments documented x-rays or the need for x-rays The Annual Dental Summaries for 18 individuals were reviewed. The summaries included treatment dates and based on these data, all individuals reviewed were being seen in the clinic on a quarterly basis for prophylactic treatment by either the dentist or the hygienist. In some cases, individuals refused treatment. Management of those individuals is discussed further under barriers to dental treatment. The following are examples of information taken from summaries reviewed: • Individual #132 completed an annual exam on 6/6/12. The annual summary submitted on 8/8/12 documented the need for a root canal and repair of lost fillings. Completion of this treatment could not be verified in dental documents submitted. • Individual #50 had multiple oral hygiene exams as well as an annual exam on 8/19/12. The oral hygiene was reported as good. The summary reported that IV sedation was needed for prophylaxis and exam. The individual had sedation in 2009 and 2010. It was not clear if the individual had prophylaxis in 2011. The summary indicated no assistance was needed for oral hygiene since it was good. It was not clear how extensive of an exam this individual had given the need for IV sedation for prophylaxis. As part of the facility's requirement to provide assessments and evaluate the quality of those assessments, the state dental service coordinator will need to develop tools to	

#	Provision	Assessment of Status	Compliance
		assess the quality of dental assessments. This should fold into the facility's dental peer review process. Management of assessments is discussed further in section H1. Initial Exams The facility submitted data for 16 individuals admitted since the last onsite review. Fifteen of 16 (93%) individuals completed initial dental evaluations within 30 days. Dental Records Dental records consisted of initial/annual exams, annual dental summary, dental progress treatment records, and documentation in the integrated progress notes. Providers documented in the integrated progress notes. During previous reviews, the legibility of IPN documentation was problematic. The new dental director addressed this through the use of electronic entries. For recent dental care, there were electronic IPN entries that were written in the required SOAP format. An identical entry was found in the dental treatment records. The entries were dated, timed, and signed. The annual dental summaries were expanded to include additional information, such as risk assessment, treatment provided, oral hygiene ratings, self-care assessment, present conditions, needs, behavioral assessment, and in some instances, the recommendations for additional treatments. Failed Appointments The facility reported data on refusals, no shows, and excused appointments. The numbers as identified and reported by SGSSLC in the document request are summarized in the table below: See table below The average failure rate for the months reported was 22%. The majority of failed appointments were due to no shows, which generally indicated the reason was unknown. It was also noted that some excused absences had no known reason. Reasons documented included dental equipment failure, home visits, illness, and medical appointments. A review of the submissions by the IDTs also indicated that the classifications of the failed appointments did not always appear appropriate. For example, Individual #153	

	Apr	May	Jun	Jul	Aug	Sep	Oct
No Show	11	14	40	10	5	20	29
Excused	1	12	11	2	7	8	18
Refused	2	7	11	18	17	9	7
Total Failed	14	33	62	30	49	37	54
% Failed	17	16	28	16	22	26	32
Total Appointments	82	198	225	185	227	140	168

#	Provision	Assessment of Status	Compliance
		was reported to "unequivocally" have stated that the individual was not attending clinic, yet the failure was classified as a no show. Individual #175 refused to go to clinic, but the IDT later explained this was a misunderstanding. The failure was classified as a no show. The emails also indicated repetitively that no explanations were needed for those individuals who were excused, explanations were required by the monitoring team for other failed appointments, and there could be no refusals with the Settlement Agreement. The monitoring team offers the following clarifications: • The creation of a classification of excused appointments is unique to SGSSLC and in no way relieves the facility of the requirement to address such failures. Moreover, an appointment should not be classified as excused when the cause is unknown. If an individual is ill, a missed appointment cannot be prevented, however, a missed appointment because the facility failed to plan and schedule adequately is another issue. It does not require intervention for the individual, but should require action on the part of the facility. There should be a means to distinguish between these issues. It may be more appropriate to consider these failures as missed rather than excused. With the exception of illness and required medical appointments, missed appointments also require strategies. • It is recognized that refusals will occur. The expectation is that the facility have a system in place that promptly identifies individuals, assesses these individuals, decides on treatment options/plans, implements the treatments, assesses the responses to treatment and makes changes in plan/strategies as required. <u>Dental Restraints</u> The dental clinic documentation listed one individual as receiving pretreatment sedation. The listing did not include the date or medication used. Additionally, the facility sedation list included a different medication dose and listed the medication as a medical restraint and not a dental restraint. The facility implemented a new process to address pretreatment sedation and the clinic was conducting more assessments with psychology regarding the needs of individuals. It will be important to maintain accurate data regarding medications used and the effectiveness of the medications. <u>Strategies to Overcome Barriers to Dental Treatment</u> The facility's refusal rate for April 2012 through October 2012 was 5%. The dental hygienist reported that the facility changed the management of refusals and no shows. The IDT was no longer required to create strategies for a single missed appointment because the team met monthly and addressed every failed appointment.	

#	Provision	Assessment of Status	Compliance
		The IDT would submit strategies to the dental clinic only if there were three failed appointments. The facility conducted a desensitization PIT meeting, however, the monitoring team was not notified of this meeting. Information was obtained from the dental clinic staff. The facility submitted its desensitization tracking log. This was reported to be the updated document. This document did not specifically identify those individuals in need of plans for dental treatment. The document lacked information, such as the date of plan, date of staff training, and date of implementation. There were no recent referrals from dental clinic, although dental clinic notes often included comments about referring to psychology for assessment. Four dental desensitization plans were reviewed. All appeared individualized and appropriate for the problems being addressed. The effectiveness of the plans could not be determined because follow-up documentation was not adequate. Psychology notes were infrequent. The plan for Individual #225 was implemented on 5/4/12. A psychology note was dated 6/12 regarding staff training. The next entry was 10/16/12 and stated there was no follow-up in the individual's notebook and direct care professionals would need to be retrained. The plan for Individual #18 was implemented on 5/9/12. The psychology entry on 5/11/12 documented staff training. The next entry on 10/16/12 documented that there was no documentation of follow-up in the individual's notebook and direct care professionals would need to be retrained. The other two plans submitted were implemented in October 2012. Individual #321 had refusals and no shows for dental clinic. The annual dental summary stated, "there was dental decay on radiographs" taken in July 2012. The individual needed a root canal and a filling. The plan for achieving this was not clear. The desensitization-tracking log stated no recommendation for treatment. Individual #57 allowed oral hygiene exams, but refused prophylactic treatment on multiple visits. Oral hygiene ratings were good, but marginal generalized gingivitis was reported with no decay. The behavior was classified as poor. The plan for providing treatment to this individual was not clear from the documentation provided. Throughout the conduct of the review, through interviews, observations and document reviews, it was clear that the facility was making efforts to address many of the issues. The dental documentation by the dental director frequently noted examinations that were done in the presence of one particular psychologist who assessed the ability of individuals to tolerate dental treatments. The dental clinic staff were very appreciative of these efforts and believed that this approach was going to benefit the individuals. The	

#	Provision	Assessment of Status	Compliance
		desensitization tracking log reflected recent treatment strategy entries by this psychology staff. Emails provided also described various approaches used by the teams to improve outcomes. Nonetheless, the monitoring team was very concerned by the lack of follow-up related to desensitization plans. It was also concerning that individuals who had a need for dental treatment had been identified as not needing treatment based on psychology evaluations but continued to refuse dental treatment. In order for individuals to have strategies and interventions implemented, refusals must be documented. The monitoring team is concerned about the accuracy of the classification of refusals as well as the assurance that refusals will be promptly identified and referred to psychology in a timely manner for assessment. This provision remained in noncompliance.	

Recommendations:

1. The dental director should continue the comprehensive assessments of individuals to determine if there are any outstanding needs are treatment issues (Q1).

2. The emergency services policy should be revised to reflect the requirement for on call dental coverage (Q1).

3. The facility should continue to secure an agreement with outside providers to ensure additional or specialty services can be provided quickly when required (Q1).

4. The facility needs to ensure that all individuals who refuse treatment are being appropriately identified, evaluated and managed (Q2).

5. The state dental services coordinator should develop tools to determine the quality of the dental assessments completed at the facility (Q2).

6. The dental department must ensure that the failed appointments are being appropriately classified. There should be no unknown excused appointments (Q2).

7. The facility should consider eliminating the category of excused appointments and replacing it with missed appointment with every missed appointment being addressed at some level in the facility (Q2).

8. The facility should continue its desensitization efforts and ensure that all individuals with continued refusals are promptly assessed (Q2).

9. The facility must address the problem of missed appointments due to no shows, scheduled outings, etc. (Q2).

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions list o Budgeted, Filled, and Unfilled Positions list, Section I o Speech Staff list and CVs o SLP Continuing Education documentation o Section R Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Section R QA Reports o Habilitation Therapy Assessment Procedure (Draft) o Speech Language Pathology Screen template and guidelines o Samples of Speech Language Pathology Screen o Samples of Speech Language Pathology Assessment Audits o Communication Master Plan o Tracking Log of Completed Assessments Since Last Review o Speech Pathology Assessment template o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o List of individuals with PBSPs o List of individuals with AAC o Compliance Monitoring tool template o Completed Compliance Monitoring forms submitted o Completed Effectiveness Monitoring forms submitted o List of individuals receiving direct speech services o Behavior Therapy Committee meeting minutes o NEO curriculum materials related to communication and AAC, tests and checklists o Samples of Communication Competency Check-Offs and guidelines o Communication Assessments, ISPs and ISPAs for the following : • Individual #202, Individual #379, Individual #295, Individual #177, Individual #384, Individual #323, Individual #253, Individual #98, Individual #385, and Individual #64 o Communication Assessments, ISPs, ISPAs, SPOs, and communication and AAC-related documentation for the following: • Individual #183, Individual #201, Individual #144, Individual #146, Individual #388, and Individual #338 o Communication Assessments for individuals recently admitted: • Individual #370, Individual #283, Individual #207, Individual #35, and Individual #220 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk

	Rating forms and Action Plans, ISP reviews by QDDP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. o PNMP section in Individual Notebooks for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #251, Individual #104, Individual #40, Individual #21, Individual #140, Individual #188, Individual #7, Individual #150, Individual #352, Individual #85, Individual #178, Individual #112, Individual #77, Individual #222, Individual #76, Individual #203, Individual #128, Individual #59, Individual #34, Individual #137, and Individual #66. <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Habilitation Therapies Director o Erin Bristo, MS, CCC/SLP o Susan Holler, MS, CCC-SLP o Susan Reeves, MS, CCC-SLP o Brittenee Valade, MS, CCC-SLP o Krista Roberts, Speech Assistant o Communication treatment sessions for Kenny Mineer and Andy Lamantz o ISP Meeting for Individual #127 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas o OT/PT Treatment Rooms

	Observations Conducted: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: In the self-assessment, Dena Johnston, OTR, the Rehabilitation Therapies Director, outlined specific self-assessment activities and provided specific data based on the findings from these activities. The activities were similar to the process used by the monitoring team, and included many of the same or similar key elements used for review and outlined in this report. R1 was self-rated in noncompliance by the facility due to an inadequate number of speech therapy professionals. The monitoring team concurred with this finding, but commends the facility for their ongoing efforts (with some success) to obtain contract clinicians and to convert an existing COTA position to a speech assistant position. Each of the clinicians currently providing services appeared to be exceptional; the challenge will be to retain them. Issues related to the consistency of hours provided by the part-time contractors were of ongoing concern. The director appeared to be making every effort to recruit and maintained good documentation to that end. The work environment provided in the department was positive as evidenced by the retention of long-term employees and the recent return of a previous employee. The addition of Erin Bristo, MS, CCC-SLP and the assignment of leadership responsibilities to her was an excellent idea and she appeared to deliver as expected. Working closely with Ms. Johnston also afforded important mentoring and collaboration for movement toward compliance in all areas of section R. R2 through R4 were not found to be incompliance by the monitoring team as outlined below and this was consistent with the self-ratings by the facility. Excellent progress, however, was made in each of these areas and the measures of success will ensure continued movement toward compliance. The data reported clearly related to each of the provision sections and were logically presented. This allowed the department to readily track their own progress and compare their findings with that of the monitoring team. The director's approach to this process continued to be refined and improved with each round of monitoring. The following should be considered: • The ISPs should include a description of how the individual communicates and strategies for staff to use as communication partners. This area needs improvement and the monitoring team is hopeful that the new ISP process will address this. • Monitoring of communication supports and services should also be based on needs for these services, not merely based on health risk levels as they may not be parallel. • Consider consulting with psychology on how they were successful in obtaining improved compliance with the implementation of and documentation related to behavior plans. • While the majority of AAC systems implemented were appropriate, there were likely other individuals who would benefit from these supports, but it would not be possible to know the actual need without completed assessments.

	The action plans developed were on point and would assist the department in moving along the continuum toward substantial compliance. It was impressive that the majority of actions had been completed and this and strong leadership were likely significant factors in the consistent progress made with this provision despite the limitations of staffing.
	Summary of Monitor's Assessment: The monitoring team was extremely impressed with the continued progress of SGSSLC with this provision. The therapists implemented some very excellent programs and the completed assessments were significantly improved. They are commended for their efforts in moving toward substantial compliance. Staffing levels were improved at the time of this review, with the addition of a speech assistant and the use of a full time contract therapist. The knowledge and skills of all of the clinicians appeared to be very good and there was a concerted effort to ensure that they participated in ongoing continuing education related to communication and AAC. Progress with the completion of assessments continued to be an issue. The assessments that were completed were significantly improved and the system of audits was effective in raising the quality and consistency of these. The therapists were completing the assessments based on priority, but were also attempting to better coordinate this with the ISPs. This will be a key change and should result in improved integration and better time management. Attendance at the ISPs was inconsistent. As always, the SLPs were responsible for communication supports and services for all of the individuals and, as such, the current ratio for caseloads continued to be high. The therapists are commended for the level of therapeutic interventions provided. The documentation related to these, however, must be tightened up with clear rationale for initiation and termination with consistent reporting of progress toward measurable objectives. Per the documentation, the consistent provision of these interventions was not adequate. NEO training was improved and specific core competencies were established. It is hoped that carry-over of these skills will be noticeable by the time of the next review, particularly with the addition of the annual refresher content. Staff tended to see the communication system as an exercise or as a single activity rather than as a way to interact with others. This cannot only be taught or trained in an inservice class, but must also be modeled and coached in the moment. Teaching them to actually use the system in their routine communications with the individual had proven to also be effective. A system of effectiveness monitoring had been implemented. This system appeared to be effective to identify issues related to communication supports. It was reported, however, that the staff compliance scores were not generally consistent with typical implementation. It was likely that staff performance was improved with direct observation, but that routine implementation was not consistent. Integration of communication strategies and AAC systems should not be the sole responsibility of direct support and day program staff. Engagement in more functional skill acquisition activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be an ongoing priority. This will only be possible when the clinicians are sufficiently

	available to model, train, and coach direct support staff, and to assist in the development of these programs for individuals and groups. This requires significant time from the professional staff. It is also critical, however, that adequate supervision and clear expectations outlined by all administrative personnel that accurate and consistent implementation of all necessary supports is a vital responsibility for all staff, at all times, even when no one is watching. Evaluation of the frequency and consistency of implementation of communication supports and programs was a key indicator that was not reported at this time.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>Staffing</u> At the time of this review, there were four SLPs, one audiologist, and a speech assistant. Erin Bristo, MS, CCC/SLP was full time state employee. She was a PNMT member, provided dysphagia services, coordinated the contract therapists, and assisted the director, Dena Johnston, OTR with section R provision tasks and action plans. Susan Holler, MS, CCC-SLP (up to 30 hours per week), Susan Reeves, MS, CCC-SLP (ranged from 15 to 25 hours per week), and Brittenee Valade, MS, CCC-SLP (full time as of 11/1/12) were each contract SLPs. Additionally, there was an audiologist, Susan Bradley, MS, CCC/A. Ms. Holler completed assessments, attended PBSP meetings and was working on the establishment of an Autism Development Center. Ms. Reeves completed communication assessments for individuals who were newly admitted to SGSSLC. A full time speech assistant position had been converted from a position for a COTA. Per the documentation submitted, service hours for the SLPs averaged only 2.3 FTEs over a period of 11 months from November 2011 through September 2012. Not all of the hours were related to communication services as Ms. Bristo also provided dysphagia- and mealtime-related services. She also was assigned administrative duties and, as such, this was not likely an accurate representation of the available hours for communication supports. This improved, however, with the additions of the full time contract SLP and the speech assistant in the last month. Three full time SLPs positions and one assistant position had been requested, but not yet approved at the time of this review. A list submitted related to positions budgeted and filled identified that there were four positions budgeted with only two filled. One of these was the audiologist who provided services to the entire facility and specifically to those with hearing impairments. While she provided the hearing/audiology aspect of the communication assessment, she was not responsible for the provision of communication supports and services other than hearing/audiology. Ms. Bristo was considered to be the other full-time position, as described above. The facility's documented ratio was 1:116. The speech assistant provided a very valuable service related to interventions, training and monitoring, but only under the supervision of an SLP and was not able to conduct assessment, per the state practice act and, as such, would not directly be included in the service ratio. Given the actual staffing for the three therapists who provided communication services	Noncompliance

#	Provision	Assessment of Status	Compliance
		(including assessment), the ratio was approximately 1:112 based on the census of 223, including the two full time clinicians, or approximately 1:74 if the part time contract clinicians were also included as one FTE. These caseloads were high and this was of concern to the monitoring team. <u>Qualifications</u> • 4 of 4 SLPs (100%) were licensed to practice as SLPs; license numbers were submitted for each. • Only two of these were verified online (50%). The licenses of both the previous assistant and the audiologist were also verified as current. The license for Ms. Holler was identified as expired as of 11/30/12 and it was not possible to verify Ms. Valade's license using the number provided. The new speech assistant was not included as she was newly hired and it was not possible to verify her license. • ASHA certification numbers were not requested for this review. Evidence that the facility consistently verified both state licensure and ASHA certification for each clinician will be requested prior to the next compliance review. <u>Continuing Education:</u> A list was submitted as evidence of participation in communication-related continuing education in the last 12 months. None was submitted for the newly hired SLP or speech assistant. Participation in continuing education for these two clinicians was expected over the next six months. • 2 of the 4 (50%) current SLPs and the previous speech assistant participated in continuing education related to communication in the last year, including the following: o ASHA Convention – Atlanta (18.25 hours) o Evidence Based Practice for AAC Evaluations -Denton (12 hours) o Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (11 – 17.5 hours) o Partners in Literacy (6 hours) It was further reported that two of the clinicians attended the DADS-sponsored Habilitation Therapy Annual Conference and also that they presented a portion of the program related to collaboration between SLPs and psychology. The content and contact hours were not known for these. This level of participation was excellent for these clinicians. The monitoring team congratulates the facility and their support of continuing education for the speech staff. The monitoring team further urges that each of the clinicians be provided continued support to participate in additional communication-related continuing education courses	

#	Provision	Assessment of Status	Compliance
		over the next year. This is critical to ensure improved clinical assessment and program development for AAC and language for individuals with developmental disabilities. <u>Facility Policy</u> No specific local policy was submitted for the provision of communication services at SGSSLC, though a draft procedure related to Habilitation Therapy Assessments had been developed. The following minimum components should be considered in the development of a facility policy: • Outlined assessment schedule (included in the draft) • Timelines for completion of new admission assessments (included in the draft) • Roles and responsibilities of the SLPs (included in the draft) • Frequency of assessments/updates (included in the draft) • Timelines for completion of comprehensive assessments (included in the draft) • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT or within 10 working days of the ISP). • A process for effectiveness monitoring by the SLP • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment • Methods of tracking progress and documentation standards related to intervention plans • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. This provision was found to be in noncompliance due to inadequate staffing. The facility was tracking continuing education and a specific effort to ensure participation for all clinicians appeared to be in place. Review of the current policies and procedures should be conducted to ensure that they minimally addressed the components outlined above.	

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R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	Assessment Plan The Master Plan submitted was dated 10/19/12. It identified that individuals newly admitted would receive a comprehensive assessment within 29 days of admission, though the draft policy indicated that a screening would be completed. In the case that communication needs were identified via screening, a comprehensive assessment would be initiated and completed within 30 days. If communication needs were not identified a screening would be completed every five years. The Master Plan continued to list the five priority levels of individuals, which directed the completion of assessments. All individuals who were provided communication supports and services, would be provided an annual re-assessment prior to the annual ISP. These were newly referred to as an Assessment of Current Status. Based on a previous review, SGSSLC had planned to conduct audits of assessments completed prior to December 2011. At that time it was determined that any assessments not considered to be within 80% compliance, would be re-done. These findings were not included in the documentation submitted for this review. The tracking logs submitted identified the following individuals with assessments completed since December 2011: • Priority 1: 10 of 35 • Priority 2: 11 of 25 • Priority 3: 16 of 30 • Priority 4: 2 of 69 • Priority 5: 0 of 37 • Non-Prioritized: 20 of 27 Based on this documentation, it appeared that only 59 individuals or 26% of the current census had been provided a communication assessment. It could not be determined if any of the assessments completed prior to December 2011 met the current standards for an acceptable comprehensive communication assessment. It was reported that 14 individuals were newly admitted to SGSSLC from April 2012 to 9/21/12. By report, 7 of the 14 (50%) new admission assessments had been completed within five days prior to the ISP from July 2012 through September 2012. Data for October 2012 and November 2012 were not available. The self-assessment indicated that 11 of 13 assessments were completed or 85%. While these may have eventually been completed, they had not been completed in a timely manner prior to the ISP. Data related to the progression with the Master Plan per the self-assessment indicated the following: • Priority 1: averaged 98% over a six month period, April 2012 to September 2012 • Priority 2: averaged 100% over the same six month period • Priority 3: averaged 47% over the same six month period	Noncompliance

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		• Priority 4: averaged 3% over the same six month period • Priority 5: 4% over the same six month period It was further reported that 109 of 230 comprehensive assessments were completed for September 2012. It was not clear how this was calculated, however, because only 38 assessments were listed as completed since the last review per a tracking log submitted (document XV.10). There were 21 of these identified as comprehensive while the others were annual assessment updates. The Master Plan listed 32 individuals identified as Priority 1, 2, or 3 who had not been provided an assessment since 2010 and or 2009. Based on review of the documents submitted: • 12 of 14 individuals (86%) admitted since the previous review had received a communication assessment, though only nine (64%) were completed within five days prior to the ISP. There was a discrepancy in the ISP date reported for Individual #108, though it appeared that her ISP had been held on 9/19/12 and, as such, the communication assessment was not completed five days prior. • The facility recently initiated a process whereby individuals newly admitted would receive a screening upon admission. A sample of five of these was submitted with four of the five identified with no need for specific communication-related supports or services. In the case of Individual #248, her failed screening was attributed to possible depression. An ISP and consult with psychology was recommended. It was not clear, however, if a comprehensive communication assessment was required. • Only 16 of 38 individuals (42%) had communication assessments completed on or before the due date listed in the tracking log of completed assessments since the previous monitoring team review. <u>Communication Assessments</u> Communication assessments were requested and submitted as follows: • Individuals in the sample selected by the monitoring team (19 of 21 were submitted) • Five of the most current assessments by each speech clinician (12 were submitted for three SLPs) • Individuals newly admitted to SGSSLC (five were submitted) • Individuals who participated in direct communication intervention, had SAPs, were provided AAC, had PBSPs, and/or presented with severe language deficits (assessments for five individuals were requested and submitted). The most current assessments for some individuals were completed more than 12 months ago, though annual assessments/updates would be expected for each based on	

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		supports and services or assessment recommendations (Individual #183, Individual #7, Individual #150, Individual #178, Individual #251, Individual #40, Individual #222, and Individual #128). The current assessment for Individual #66 (8/7/12) was duplicated. All totaled, there were current assessments for 40 individuals available for review as follows: • Comprehensive Communication Assessment/Speech-Language Evaluation (18) • Speech-Language Evaluation (10) • Speech Therapy Evaluation Update (8) • Speech-Language Update (1) • Speech-Language Therapy Annual Review (8) Priority Levels of individuals for whom assessments were submitted were as follows: • Priority 1 (10) • Priority 2 (10) • Priority 3 (9) • Priority 4 (3) • Priority 5 (1) • Non-Prioritized (6), each was newly admitted to SGSSLC • Not in Master Plan (1) Of these, three individuals had multiple assessments: Individual #128 (10/31/11 and 8/10/12), Individual #59 (1/29/09, 4/13/09, and 2/25/10), and Individual #188 (6/23/09 and 11/21/12). • Individual #188 was provided a comprehensive assessment completed just in the last month, though she had not received a communication assessment since 2009 (annual review) despite a significant change in health status in the last year. She was identified as Priority Level 5. • Individual #59 was provided an evaluation in January 2009, an update in April 2009, and an annual review in February 2010. None of these was comprehensive and while the most recent indicated that direct intervention was not required, the need for a subsequent evaluation was not clearly stated. He was identified as Priority Level 3. • Individual #128 was provided an evaluation on 10/31/11. The update completed on 8/14/12 included additional information not addressed in the 2011 evaluation, however, it was not clear if there had been any changes in the data reported at that time. As would be expected, both of these were contained in the individual record. He was identified as Priority Level 2.	

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		Of those identified as Priority 1, only five individuals were provided a current comprehensive assessment. Two were provided updates in the last 12 months (Individual #253 and Individual #323). The other three were provided Speech-language Evaluations that were not considered to be comprehensive, each of which had been completed over two years ago. Of those identified as Priority 2, four individuals were provided a speech-language evaluation in 2011, though these did not appear to be comprehensive and five individuals were provided evaluation updates in 2012. Most of these were identified as an update to a comprehensive evaluation completed in 2011 or an update to an evaluation completed in 2010 for Individual #194. Individual #34 only had an annual review dated 4/20/10. Consistent with the annual reviews described above, these were not comprehensive and did not reference a previous comprehensive assessment. The review for Individual #34 did not indicate when a comprehensive assessment would be provided, though this would be expected because he was likely to benefit from communication supports. He had limited language skills and it was stated that problem behaviors might have been exacerbated due to diminished communication function. Of those identified at Priority Level 3, six individuals had been provided a comprehensive assessment, each completed in the last year. Two (Individual #59 and Individual #178) were provided a speech/language evaluation (not comprehensive) in 2009. As described above, Individual #59 also received an update in April 2009 and an annual review in 2010. As Priority 3, each of these individuals had potential to benefit from communication supports. In fact, Individual #178 was described to have a need for AAC. The comprehensive evaluations (18), included six individuals who had been newly admitted to SGSSLC, were completed in the last year. The evaluation updates (8) submitted were also completed in 2012. The update for Individual #59 (described above) was previously completed over three years ago. A comprehensive assessment should be completed for each individual currently living at SGSSLC. It was reported that any evaluation completed prior to October 2011 was to be redone. In the case that supports and services were not indicated (because the individual presented with very functional communication skills and did not present with challenging behaviors related to communication deficits), it should be clearly stated that no supports and services were needed and if or when a reevaluation would be completed. By report, a comprehensive evaluation was to be completed every five years for individuals who required supports. The Assessment of Current Status was to be completed each year in the interim. For those who did not require communication supports, a re-screening would be completed every five years.	

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		In the case that any supports or services were provided over the previous year, an annual update (Assessment of Current status) should be completed that reports the individual's health status, risk ratings, and any changes over the last year. This assessment, at a minimum, should also describe the supports and services provided, the effectiveness of these, and recommendations for the upcoming year. It did not appear that these critical updates were consistently completed at the time of this review. A template for the comprehensive communication assessments was submitted as adopted at SGSSLC. There were functional guidelines to guide content for these. There was also a format for Assessment of Current Status. None of the assessments submitted were identified as an Assessment of Current Status, but rather evaluation updates. The assessments were not consistent with the template, though it had been reported that this had been recently revised to reflect identified needs for improvement in the initial template. The current risk level information was moved to the back of the assessment, so that it became an aspect of the data used for clinical analysis versus an element of chart review and reporting when in the front of the assessment. PFA information was included in order to address preferences that were missing from the original template. The clinical impressions section was expanded and a recommended schedule for monitoring was added. These were positive improvements. Only one assessment was not consistent with the revised format (Individual #188, 11/19/12). The comprehensive assessment for Individual #35 was incomplete (missing page two) so it was not included in the following analysis. Zero of 17 individuals had a comprehensive assessment that contained <u>all</u> of the 23 elements outlined below, however, there were 11 elements present in 100% of the assessments reviewed and another four elements were present in 80% of the assessments. In the case that these elements did not apply, this was factored into the calculations. These were the minimum basic elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team. Seven of these elements were missing or they were inadequately addressed in many of the assessments reviewed. The current assessment format and content guidelines did not specifically address each of these at this time. The elements most consistently included (contained in more than 80% of the assessments reviewed) were: • Diagnoses and relevance of impact on communication. • Individual preferences, strengths, interests, likes, dislikes. • Medical history and relevance to communication • Medications and side effects relevant to communication.	

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		• Documentation of risk levels and how these may impact communication skills. • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. • Discussion of the expansion of the individual's current abilities. • Discussion of the individual's potential to develop new communication skills. • Addressed the individual's AAC needs including clear clinical justification and rationale as to whether the individual would benefit from AAC. • Identify need for direct or indirect speech language services. • Reassessment schedule. • Monitoring schedule. • Factors for community placement. Manner in which strategies, interventions, and programs should be utilized throughout the day. The percentage of assessments that included each individual element are listed below: • Dated as completed 10 days prior to the annual ISP (47%). • Diagnoses and relevance of impact on communication (94%). Increased from 61% in the previous review. • Individual preferences, strengths, interests, likes, and dislikes (100%). Increased from 67% in the previous review. • Medical history (over at least the previous 12 months) and relevance to communication (88%). Increased from 56% in the previous review. There was limited discussion of the individuals' medical history and health status during the last year. • Medications and side effects relevant to communication (100%). Increased from 67% in the previous review. Many did a very good job of tying these to communication. • Documentation of how the individuals' communication abilities related to their health risk levels (100%). This section typically addressed only those risk areas that the clinician believed pertained to communication. This area should identify high and medium risk areas and a statement as to any changes or findings that impact the risk ratings should be addressed in the clinical impressions section of the report. • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day (100%). This was not scored during the previous review. This was a strength at this time. • Description of receptive communication skills with examples of how these skills were utilized in a functional manner throughout the day (100%). This was a strength. • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) (59%).	

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		• Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal (55%). The clinicians did not provide examples of information included in the dictionaries, did not typically discuss if these were still accurate and effective, and did not discuss specific changes needed. • Discussion of the expansion of the individual's current abilities (100%). Increased from 53% in the previous review. • Discussion of the individual's potential to develop new communication skills (93%). Increased from 69% in the previous review. • Effectiveness of current supports, including monitoring findings (14%). This was not consistently present in the assessments reviewed and only a couple presented findings from monitoring conducted throughout the last year. • Addressed the individual's AAC needs including clear clinical justification and rationale as to whether the individual would benefit from AAC (100%). Increased from 44% in the previous review. • Comparative analysis of health/functional status from the previous year (8%). • Comparative analysis of current communication function with previous assessments (53%). • Identify need for direct or indirect speech language services (100%). Increased from 36% in the previous review. • Reassessment schedule (100%). Increased from 67% in the previous review. • Monitoring schedule (94%). Increased from 67% in the previous review. Frequency of monitoring for effectiveness, compliance and maintenance should be outlined. • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits (76%). • Factors for community placement (100%). Increased from 72% in the previous review. • Recommendations for services and supports in the community (12%). There were very few actual recommendations for supports and services, most of the statements were factors to consider for community placement. Needs for SLP services should be outlined related to services, monitoring, and staff training related to communication skills and AAC use. • Manner in which strategies, interventions, and programs should be utilized throughout the day (100%). Increased from 36% in the previous review. In the cases in which specific communication strategies were listed in the assessment, they were generally functional and could be applied throughout the day. Consideration of more suggestions related to guide staff interactions as	

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		communication partners should be considered. Additional findings: • 0 of 17 (0%) assessments contained less than 70% of the above elements. • 7 of 17 (41%) contained 70% to 79% of the elements outlined above. • 9 of 17 (53%) contained 80% to 89% of the elements outlined above. • 1 of 17 (6%) contained 90% or more of the 23 elements outlined above. • In the previous review, 20 of 36 (56%) assessments contained 10 or fewer (43% or less) of the elements. • The assessments did not typically identify important life activities or inventory ways for greater meaningful participation in them. There were at least 60 individuals listed with significant language deficits (Priority 1 and 2). Each of these was listed as Priority 1 in the Master Plan. Only 41 of the 60 (68%) were listed with comprehensive communication assessments, completed since January 2011. The others had not received an assessment since 2010 and, as such, would not likely be considered comprehensive. Four of these had been provided an annual update during this last year and were included as comprehensive based on the new guidelines. Continued progress with completion of these was indicated over the next year. That said, the completed assessments were much improved. Many were very good and aspects of most of the assessments were excellent. <u>SLP and Psychology Collaboration</u> There were 28 individuals listed with behavioral challenges and co-existing severe language deficits. Each was identified as Priority 1 and each had a PBSP. There were 14 who had not been provided a comprehensive communication assessment since 2010. There were 169 individuals with PBSPs that included replacement behaviors related to communication. Sixteen of these were identified as Priority 1, but eight had not been provided comprehensive communication assessments since 2010. There was no evidence that any updates had been provided for these individuals. Twenty others had been identified as Priority 2 and two of these had not been provided communication assessments since 2010 with no evidence of updates since that time. Twenty-one individuals had been identified as Priority 3 and eight of these had not been provided an assessment since 2010 with no evidence of updates since that time. Six of these had not received a communication assessment since 2009. There were at least 78 other individuals with PBSPs and communication replacement behaviors included in the Master Plan who had not received a communication assessment since 2010 and nine others for whom there was no evidence that they had ever been provided an assessment.	

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		Twelve of the individuals with behavior concerns described above were included in the sample selected by the monitoring team. Their PBSPs and communication assessments were reviewed to determine if the communication strategies were integrated into their PBSP and ISPs. Overall, they were not. Comments are below: • Individual #7: Her most current communication assessment was dated 10/7/10. There was no reference to behavior issues or a PBSP in this assessment. While direct services were not recommended, she was provided a communication dictionary and, as such, an update would be required for her annual ISPs. There was no evidence that these had been provided. The PBSP in her individual record was dated 2/6/09 with no evidence of review or revision since then. Thus, Individual #7 did not have a current PBSP or communication assessment even though she had been identified with high needs in both areas. She was listed with a recordable button communicator, but it was not referenced in the PBSP. There was no evidence of collaboration between the SLP and psychology. • Individual #34, Individual #59, Individual #76, Individual #40, and Individual #21: Their most current communication assessments were very brief annual reviews completed in 2009 or 2010 and were not comprehensive. There was no reference to the PBSP or specific challenging behaviors and there was no evidence of collaboration between the SLP and psychology. Individual #40's PBSP was dated 3/3/10 with no evidence of review since that time. • Individual #150, Individual #203, Individual #251, and Individual #222: Their most current communication assessments were completed in 2010 or 2011. There was no reference to challenging behaviors or their PBSPs. There was no evidence of collaboration between the SLP and psychology. Per her PBSP, Individual #203 was to use an AAC system, but there was no evidence that this had been recommended in her communication assessment. She was identified as using a community AAC display. There was no evidence of collaboration between the SLP and psychology. • Individual #137: Her most current communication assessment was completed on 2/22/12 and was comprehensive. Recommendations included facilitated drawing to address changes in her schedule and increase her language comprehension. As her ISP had occurred prior to this time and her most current PBSP was dated 2/25/11, there was no reference to this strategy. There was no evidence of collaboration between the SLP and psychology. • Individual #128: Specific strategies were recommended in the evaluation update on 6/14/12, completed nearly three months after his ISP on 3/26/12. His PBSP was developed on 2/23/12 and the strategies in this plan were not consistent with those in the communication assessment. There was no evidence of collaboration between the SLP and psychology.	

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		Behavior Management Committee meeting minutes from 6/6/12 to 7/25/12 were reviewed. An SLP attended four of seven meetings (only 57%). Observation by the monitoring team at a BMC meeting during the onsite review showed that the SLP was a very valuable member of the team and brought important information and insight to the discussion. This was a key opportunity for discussions regarding effective communication strategies and for collaboration between the SLPs and psychologists in the review of PBSPs. Collaboration during assessments would also be an important element to ensure consistency and optimal effectiveness. SLP attendance at these meetings should be more consistent. There was potential for additional collaboration. The current communication assessment format included a section titled Behavioral Considerations, which indicated if the individual had a PBSP and the types of behaviors noted during the assessment. While each of these were steps toward compliance in this area, the quality of content of this section varied across assessments, did not describe any collaboration between these disciplines, and was not consistently used in the analysis of assessment findings section for the design of communication supports and services, or for making recommendations. <u>Assessment Audits</u> There was an established system of communication assessment audits. The draft policy outlined the following process: • Therapists submitted all completed assessments to the director of rehabilitation for auditing within five days of submission. • Each therapist was to achieve three consecutive competency scores of 80% or greater. • The therapist had two calendar days to review and revise the assessment after the audit and submit to the IDT. • Once competency was established, compliance monitoring was conducted by the selection of one assessment per month for auditing by the director. Compliance of 80% or greater was required. • If the score was less than 80%, a corrective action plan was developed to reestablish and maintain competency. A sample of approximately 33 assessments was reported to have been audited with compliance scores ranging from 76% to 88%, with an average of 84% from April 2012 to September 2012. Unfortunately, the scores had diminished significantly in September 2012 (from 88% to 76%) with no explanation provided. A process to include inter-rater scores had been initiated that same month and was reported to be 66%.	

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		Two assessments (Individual #188 and Individual #127) were scored by the monitoring team using the audit tool developed for that purpose and in use at SGSSLC. The monitoring team's ratings were compared to those obtained by the director and were found to be consistent in both cases. The only difference noticed was in the assessment for Individual #127. The post-audit revisions to his assessment included effectiveness monitoring results, but did not include any staff compliance monitoring results. This should be addressed to ensure that proper implementation was not a factor. In general the comprehensive assessments completed using the revised format, were very good, meeting the standards of the Settlement Agreement related to content. An ongoing issue will be related to the updates/Assessments of Current Status to ensure that they will be adequate. A variation of the audit tool may be necessary to address this format.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP</u> Based on review of the sample of ISPs, the following was noted: • 35 of 41 (85%) of the individuals for whom assessments were submitted had documented communication needs. ISPs were available for review for 34 of 41 of those with assessments because the ISPs for the individuals newly admitted were not requested, the ISP for Individual #177 was expired at the time of this review, and the ISP for Individual #194 was not completed. Assessments were not submitted for Individual #85 or Individual #140 with their individual records, though ISPs were available. These ISPs did not provide an adequate description of their communication skills, though each was noted to be verbal. Each of the ISPs submitted and reviewed was current within the last 12 months. In 12 of 30 current ISPs (33%) reviewed that had sign-in sheets for individuals with communication needs, an SLP attended the annual meeting. • In 7 of 12 current ISPs (75%) reviewed for individuals with AAC, AAC was referenced (Individual #203, Individual #66, Individual #222, Individual #7, Individual #253, Individual #183, Individual #201), though how these were used by the individual was typically not described adequately. Recommendations related to communication for Individual #177 were deemed to be not necessary by the IDT per the ISP dated 9/9/11 (expired at the time of this review). In three ISPs, there was no reference to AAC (Individual #384, Individual #323, and Individual #251) beyond the communication dictionary, though other AAC systems were reportedly in use. • 24 of 38 ISPs (63%) included a description of how the individual communicated, though the adequacy of these varied greatly. Most did not include how they used their AAC system (if he or she had one). Many of the descriptions were minimal and did not provide a functional description of how the individual communicated or ways staff could effectively communicate with him or her. In many cases, the only descriptions were from the communication assessments, though a number	Noncompliance

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		of these were not current. This functional description should be an aspect of the ISP that describes the individual as a person in a holistic manner rather than merely as a reported finding in the assessments. Some specific guidelines for the QDDPs may be necessary to assist in ensuring greater consistency with the content of this this aspect of the ISPs. • 15 of 38 ISPs (39%) contained training/service objectives related to communication skills, though almost all were service objectives. Of note: o Some of the individual objectives stated only that the individual would continue to use skills he or she already had (Individual #7, Individual #66, Individual #146, and Individual #40). o Individual #104 had an action step to continue to use his communication dictionary. This was not a system for his use, but rather a guide for staff to interpret his communicative efforts. o Some were merely to obtain a communication assessment (Individual #384, Individual #98 and Individual #150) that should have been provided prior to the ISP. o The action plan for Individual #202 indicated that she would appropriately communicate her wants and needs without engaging in screaming, SIB, or physical aggression, rather than describing how she would appropriately communicate. The SLP was not identified as a responsible person. o The action plan for Individual #323 was to develop a SAP for him and his staff to practice using his communication devices rather than training objectives for him to gain a skill (also for Individual #183 and Individual #144). o Other action plans merely involved staff training related to communication systems (Individual #222 and Individual #144). o The majority of these were not focused on the acquisition of meaningful, functional communication skills for the individual with a few exceptions (Individual #144, Individual #253, and Individual #338), though these were not presented in measurable terms. o There were only two addendums to add a skill acquisition plan (Individual #388 and Individual #201) and one to review a communication assessment completed after the ISP (Individual #66). o A number of ISP addendum meetings were held to address behavioral issues related to Individual #201 (7/23/12, 7/30/12, 8/7/12, 8/13/12, 8/20/12,9/4/12, 9/7/12, 10/1/12, 10/8/12, 11/12/12, 11/26/12). Each of these addressed peer to peer aggression with the same analysis and outcomes (he is bored, not engaged in active treatment, and should have ready access to preferred sensory items). The SLP attended only one of these meetings (8/20/12). There was no discussion in	

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		subsequent meetings as to progress or effectiveness of this program. Also see section S regarding the absence of communication SAPs. <u>AAC Systems</u> It was reported that 47 individuals at SGSSLC were provided one or more types of AAC, including communication books, picture schedules, choice boards, picture cards, Put 'Em Arounds, voice output devices, Go Talk device, visual timelines, picture sequencers, social stories, recordable button communicator, scripts, display boards, Dragon Speak software (on order), and various community displays. Though most were low- or light-tech systems, they appeared to be individualized and meaningful to the individuals for whom they were intended. Another 21 individuals were provided a communication dictionary only. These were reference guides for staff to interpret individual's communicative efforts rather than supports to improve or enhance their communication abilities. There were 60 individuals identified as Priority 1 and 2 who could potentially benefit from AAC. The majority of these individuals were nonverbal or had very limited verbal skills. Fifty-seven of these were provided some type of communication support, with 45 provided AAC beyond a communication dictionary. Another 16 individuals were identified as Priority 3, some of whom would also require AAC systems to augment or enhance their existing communication skills. Ten of these individuals were provided communication dictionaries, though only Individual #345 was provided an additional choice board to select snacks and drinks. This amounted to approximately 60% of those identified by the facility to be of highest priorities for communication supports, many of whom would require AAC beyond a communication dictionary. Individual #318 was identified as Priority 4 and Dragon Speak software had been ordered for him. In the previous monitoring team report, it was noted that some type of communication support was provided for 100% of individuals identified as Priority 1, 92% of individuals identified as Priority 2, 39% of individuals identified as Priority 3, one individual at Priority 4, and one at Priority 5. The current numbers remained similar as follows, with an increase in Priority 3: • Priority 1: 100% • Priority 2: 88% • Priority 3: 64% • Priority 4: 1% (one individual) • Priority 5: 0% (none) While most of the additional individuals who were provided supports in the last six months were provided communication dictionaries, a number of others were provided	

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		additional or revised AAC supports. This is a dynamic process and will vary across time as the facility introduces new devices and discontinues others due to ineffectiveness. The monitoring team again commends SGSSLC for the number of individuals provided AAC systems (and other communication supports). There were a number of general use devices throughout the facility. For example Communication books were developed and placed in meeting rooms to assist with potential communication issues that might occur during an ISP meeting. The meaningfulness and function of the devices appeared to be very appropriate and many were noted to be in use or specific training was occurring to promote use. The clinicians appeared to understand the application and integration of AAC because there were very excellent supports in place, however, more individuals would likely benefit from AAC. <u>Direct/Indirect Communication Interventions:</u> Generally accepted professional standards of practice for documentation by the SLP related to communication interventions include the following: • Current communication assessment identifying the need for intervention with rationale. • Measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of device and/or goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Communication-related interventions (that is, direct service provided by communication department staff) were listed as provided for 15 individuals. Intervention sessions were observed during this onsite review (e.g., Individual #201, Individual #237). These sessions were implemented by the SLP. The interventions were very functional and the monitoring team was impressed with the structure and quality of these. Communication assessments were submitted for six of the individuals listed as receiving communication interventions (Individual #183, Individual #201, Individual #144,	

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		Individual #146, Individual #388, and Individual #338). Assessments for seven others were also submitted with additional requests (Individual #66, Individual #137, Individual #379, Individual #202, Individual #207, Individual #220, and Individual #35). Eleven of these individuals had a comprehensive communication assessment completed in 2012 and one (Individual #388) had an evaluation update on 8/7/12. The associated comprehensive assessment was not submitted. Only Individual #183 did not have a current assessment; the most recent completed on 11/22/10 with no updates since then. As such, this was not considered to be comprehensive. In fact direct therapy was not recommended at that time, yet he was listed as receiving direct speech services at the time of this review. Any individual who was provided with communication supports and services, particularly direct therapy, would receive an annual assessment or update if a comprehensive assessment had been previously completed. ISPs were submitted for 10 of these 13 individuals (ISPs were not requested for new admissions) and ISPAs were submitted for six individuals. Upon review, the majority of these were integrated into the annual plan or a subsequent ISPA. Comments are below: • Individual #146 (4/24/12): Per the communication assessment dated 7/10/12 (completed more than two months after the ISP), direct therapy was not recommended by the clinician. Outcomes in her ISP included only that staff would refer to her communication dictionary and that she would continue to use her voice, facial expressions, and gestures to communicate to staff. Per the list provided, direct therapy was a recommendation approved in an ISPA, however, there was no evidence of this submitted in the individual record. • Individual #66 (3/22/12): Direct speech therapy was recommended per the comprehensive assessment dated 8/7/12 (completed more than four months after the ISP). An ISPA was held on 8/1/12 to integrate the recommendations into the ISP. • Individual #388 (3/15/12): Per the evaluation update on 8/7/12 (date of signature), direct speech therapy was not recommended. This was not addressed in his ISP, though an ISPA on 8/20/12 indicated that OT/PT would work with Individual #388 and his staff to effectively use the communication and sensory devices in place for his active treatment. • Individual #183 (10/12/12): As stated above the most current communication assessment was completed two years ago on 11/22/10. His ISP indicated that the SLP would develop an "I'm a Worker" storybook and work with workshop staff to develop an appropriate immediate reinforce for him during scheduled work time. There was no ISPA related to the provision of direct speech therapy. • Individual #137, Individual #379, Individual #202: Per the comprehensive assessments direct speech therapy was not recommended. This was also not addressed in the ISPs or any subsequent ISPAs submitted.	

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		• Individual #338 (6/20/12): Direct therapy was recommended in the comprehensive assessment dated 6/19/12 and was included in this ISP. • Individual #144 (4/11/12): Direct speech therapy was not recommended in the comprehensive assessment dated 4/12/12, but appeared to be included in his ISP related to learning five basic signs. • Individual #201 (4/9/12): Direct speech therapy was not clearly recommended in the comprehensive assessment dated 8/17/12 (date of signature). This was not addressed in this ISP, but an ISP on 8/20/12, indicated that direct therapy would be provided two to three times per week for a duration of four weeks in order to model use of his communication and sensory devices. Documentation related to the communication interventions described above was reviewed in the sample selected by the monitoring team. None met the minimum basic standards outlined above. Some examples included: • Individual #144: SAP initiated on 8/19/12 per an IPN on that date. Subsequent progress notes were completed only on 9/5/12, 1/29/12, 11/30/12, 12/3/12, 12/4/12 (2). This was inadequate consistency of the provision of any direct intervention to effect positive change. There was no stated measurable outcome or SAP submitted. This documentation did not meet the minimum basic standards outlined above. • Individual #146: Initiation of staff training documented on 9/27/12. Subsequent IPNS only on 10/23/12 and 10/30/12. This was inadequate consistency of the provision of any direct intervention to effect positive change. There was no stated measurable outcome or SAP submitted. This documentation did not meet the minimum basic standards outlined above. • Individual #388: Documentation related to communication therapy noted in the IPNs for 9/5/12. This was inadequate consistency of the provision of any direct intervention to effect positive change. There was no stated measurable outcome or SAP submitted. This documentation did not meet the minimum basic standards outlined above. • Individual #338: IPN dated 6/18/12 indicated the initiation of the speech evaluation on that date. The assessment dates recorded were 6/15/12 and 6/19/12 for the ISP held on 6/20/12. Further IPN documentation was noted on 6/22/126/27/12, 6/29/12, 7/13/12, 7/25/12, 7/27/12, and 8/1/12. There was no further documentation until 11/26/12 at which time the clinician documented that direct therapy would be decreased to annual evaluation only, but there was insufficient rationale. This was inadequate consistency of the provision of any direct intervention to effect positive change. There was no stated measurable outcome or SAP submitted. This documentation did not meet the minimum basic standards outlined above.	

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		The therapists are commended for their overall efforts to provide effective communication supports and services. Consistency and documentation were problematic. Indirect communication supports were provided for a number of individuals in the manner of monitoring of communication AAC devices. This was accomplished through PNMP monitoring completed by the PNMPCs and effectiveness monitoring discussed below in R.4. <u>Competency-Based Training and Performance Check-offs</u> New employees participated in NEO classroom training prior to their assignment in the homes. The content was comprehensive, though it was not clear if opportunities for hands-on practice were provided. It was reported that a four hour block was allotted for communication content. Content was offered across six areas with core competencies established for each. Staff indicated that this time needed to be increased. At the time of this review, Ms. Bristo taught the content portion of this class and the PNMPCs, other SLPs, and COTAs assisted in the competency check-offs. The clinicians were in the process of reviewing the curriculum and the actual training was to be assigned to the PNMPCs before the end of the year. At that time, the therapists will complete the competency check-offs. They were considering repeating this training annually or possibly every six months. The curriculum was reviewed by the monitoring team and was found to be thorough, though in some cases, the content used too much professional jargon and, therefore, may not be readily understood by DSPs. Consideration for revision of the language only may be indicated. The check-off included both verbal and demonstration of skills-based activities related to the provision of cues and AAC use. This provision continued to be in noncompliance. ISPs lacked adequate descriptions of how individuals communicated and staff strategies for use as communication partners. Integration of communication supports and services was not consistently evident. The systems in place for individuals were generally excellent as functional and adaptable communication systems, however, implementation and integration throughout the day continued to be a challenge. The number of individuals participating in direct therapy improved since the previous review, but documentation was inconsistent and did not meet generally accepted professional standards of care. Expanded staff supports for the implementation of communication programs and AAC systems is needed. Much of the interaction of staff with individuals observed by the monitoring team was specific to a task, with little other interactions that were meaningful. Sometimes, there was a great deal of staff talking to/at the individuals during activities, but without appearing to understand how to facilitate better interaction, engagement, and	

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		participation with the individuals. The following should be considered: • Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology where appropriate) should continue to be a priority. This will only be possible when the clinicians are sufficiently available to routinely model, train, and coach direct support staff and to assist in the development of activities across environments and contexts. • SLPs should continue to participate in co-designing written programs and providing formal training. Implementation should be collaborative with demonstration in real time activities. Basic and individualized communication strategies should be outlined in assessments. These simple strategies or the ability to incorporate assistive technology will not be naturally intuitive for direct support professionals. They will require modeling and coaching. • Group and individual activities should be routinely co-directed by speech clinicians and DSPs in the homes, work, and day program environments, so that the clinicians can model how to appropriately use these strategies during the activities to expand and enhance staff's partnering skills as well as to expand and enhance active participation of the individuals via communication. • Also, further collaboration with OT and PT in this capacity will further promote functional and meaningful activities for individuals.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Monitoring System</u> Monitoring of communication supports was provided (and documented) with the SSLC PNMP Compliance Monitoring form. These were used to evaluate staff knowledge regarding the required supports, the presence and condition of the supportive equipment, and the appropriate implementation of the supports. The self-assessment reported that a sample of 88 monitoring forms related to communication had been completed and reviewed from April 2012 through September 2012. Average compliance was 90%. Inter-rater reliability had not yet been implemented as of 11/19/12. Revision of the current PNMP monitoring completed by the PNMPCs was being considered by the director. Failed skill drills were tracked and noted to average 6.6%. No staff failed more than one skill drill per the self-assessment. Initial failures resulted in re-training and multiple failures resulted in further training and supervision. Completed monitoring forms were requested related to communication for the month prior to the onsite review. Eight forms were submitted for September 2012. Compliance was 100%. Frequency of monitoring for communication related issues was not clear, but appeared to be based on health risk rather than communication support needs.	Noncompliance

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		A system of effectiveness monitoring had been implemented. This was a review of the PNMP, but not specifically related to communication. Twenty completed forms were submitted for the last quarter for 10 individuals. Three appeared to be semi-annual monitoring and the others were quarterly. Average compliance scores were 91%. Seven of 20 (35%) of the programs in place were identified as not effective and requiring revisions. This system appeared to be effective to identify issues related to communication supports. It was reported, however, that the staff compliance scores were not generally consistent with typical implementation. That is, it was likely that staff performance improved with direct observation, but routine implementation was not consistent. This requires adequate supervision and clear expectations that accurate and consistent implementation of all necessary supports is a vital responsibility for all staff, at all times, even when no one is watching. Evaluation of the frequency and consistency of implementation of communication supports and programs is a key indicator, but was not reported at this time. Effectiveness monitoring findings were to be documented in the individual record, but were not yet integrated with the ISP review process. The SLPs did not reference these findings in their annual assessments, however, the necessary frequency of monitoring needed was now outlined in the new formats. Monitoring of communication programs and systems should be based on level of need related to communication, though increased monitoring for an individual with changes in risk level would likely warrant monitoring across all areas to assess the impact of health status on functional performance. This provision continued to be in noncompliance. The existing system of compliance monitoring was in transition as the role of the PNMPCs was to undergo changes and a revised system was not yet in place. Consistency of implementation continued to be a major challenge.	

Recommendations:

1. Continue to pursue filling full time SLP positions (R1).

2. Continue to problem solve issues related to rate of completion of assessments. Ensure that updates are completed in a timely manner for individuals who are provided supports and services.

3. Ensure associated assessments are not prematurely purged from the individual record (R2).

4. Ensure that factors related to community placement are addressed for each individual that, minimally identify what specific supports and services would be needed for the individual when living in the community (R2).

5. Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal should be addressed in the communication assessment and reviewed routinely throughout the year (R2).

6. Improve consistency of attendance at the BSP Committee meetings as the value of this was readily noted by multiple monitoring team members.

7. Include descriptions of communication in the ISPs, with reviews of effectiveness of supports provided, including the Communication Dictionary. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (R3).

8. Ensure all supports and services are integrated into the ISPs/ISPAs (R3).

9. Develop guidelines and training for QDDPs as to how to integrate communication-related information into the ISP (R3).

10. Develop guidelines for documentation of communication supports and services to improve content and consistency (R3).

11. Evaluate NEO and other communication training to ensure that adequate time is allotted to ensure effective opportunities for presentation of content and opportunities for participants to practice skills required to implement communication programs and to be effective communication partners in the individuals' natural environments (R3).

12. Monitoring of communication supports and services should be based on need. This should address the consistency of implementation and the effectiveness of these, in addition to condition of any AAC devices or systems (R4).

13. Ensure routine effectiveness monitoring is conducted (R4).

14. Continued staff training and modeling are indicated to ensure appropriate and consistent implementation of recommended AAC systems (R3).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: o Individual #304, Individual #41, Individual #48, Individual #64, Individual #123, Individual #163, Individual #60, Individual #252, Individual #130, Individual #50, Individual #346, Individual #9, Individual #24, Individual #239 o Skill Acquisition Plans (SAPs) for: o Individual #304, Individual #41, Individual #48, Individual #64, Individual #123, Individual #163, Individual #60, Individual #252, Individual #130, Individual #50 o Functional Skills Assessment (FSA) for: o Individual #41, Individual #48, Individual #64, Individual #163, Individual #123 o Personal Focus Assessment (PFA) for: o Individual #41, Individual #48, Individual #64, Individual #163, Individual #123 o Vocational assessments for: o Individual #41, Individual #48, Individual #163, Individual #123 o Dental Desensitization Plans for: o Individual #236, and Individual #130 o Skill Acquisition Program Competency Review form, dated 9/25/12 o Section S Benchmark Analysis, dated November 2012 o Active Treatment PIT meeting minutes dated December 3 and December 7 o SGSSLC Action Information, dated 11/16/12 o SGSSLC Section S Action Plans, dated 11/16/12 o SGSSLC Section S Self-Assessment, dated 11/19/12 o Listing of on-campus and off-campus day and work program sites, undated o A list of individuals who are employed on- and off- campus, undated o A summary of community outings per residence for June, July, August, and September of 2012 o A list of all instances of skill training provided in the community for June, July, August, and September of 2012 o A list of all Individuals with dental desensitization plans, undated o List of students participating in public school educational programming, November 2012 o Training documentation for staff regarding special education laws, 8/22/12 o Notes from quarterly meeting with WISD personnel, 8/31/12, 11/28/12 o Emails between SGSSLC and WISD special education teacher at the WISD campus and the SGSSLC campus o ISPA for Individual #99 regarding participating in inclusion mainstream class at WISD, 9/4/12 o ISP, ARD/IEP, and recent IEP progress notes for o Individual #239, Individual #35, Individual #220

	Interviews and Meetings Held: o Gary Flores, Director of Cultural Services/Day Habilitation o Michael Davila, QDDP Coordinator; Tammy Ponce, Program Developer; Justin Gaston, Program Trainer o John Church, Assistant Chief Psychologist o Patricia Trout, Cedric Woodruff, Amanda Rodriquez, Unit Directors o Vicki Hinojos, Director of Residential Services and Michael Davila, QDDP Coordinator, regarding the public school program o Tammy Demeres, WISD classroom teacher at the SGSSLC campus classroom Observations Conducted: o Observation of implementation of skill acquisition plans (SAPs) for: o Individual #97, Individual #48 o Observations occurred in various day programs and residences at SGSSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals. o WISD classroom on the SGSSLC campus
	Facility Self-Assessment: Overall, SGSSLC's self-assessment included some relevant activities in the "activities engaged in" sections that were the same as those found in the monitoring team's report. For example, S2 of the self-assessment included a review of the functional skills assessments and vocational assessments to determine that they were complete, which are topics that are included in the monitoring team's review of S2. Not all activities described in the self-assessment, however, were consistent with what the monitoring team reviewed. For example, S1 of the monitoring team's report addresses the need for a clear rationale, a plan for generalization and maintenance, a review of the training methodology, and desensitization plans, which were not addressed in the facility's S1 self-assessment. The monitoring team suggests that the facility review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead the department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other, and the monitoring team's report. SGSSLC's self-assessment indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facility's findings of noncompliance in all areas. The self-assessment established long-term goals for compliance with each item of this provision. Because

	many of the items of this provision require considerable change to occur throughout the facility, and because it will likely take some time for SGSSLC to make these changes, the monitoring team suggests that the facility establish, and focus its activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Improvements since the last review included: • Increase in the percentage of SAPs reviewed that contained a rationale for its selection that was specific enough for the reader to determine that it was practical and functional for that individual (S1) • Increase in the percentage of SAPs reviewed that contained an acceptable plan for generalization (S1) • The initiation of SAP integrity measures (S3) Although there were relatively few tangible improvements in the last six months, there were some recent developments that suggest that more improvements in this provision will be evident in future reviews. These included: • The recent establishment of the Program Resources department which consists of staff exclusively dedicated to the development and implementation of skill acquisition plans (SAPs) (S1, S3) • The recent development of an engagement PIT, to improve individual engagement and participation in day programming (S1) • Training of direct care professionals (DCPs) in the implementation of SAPs (S3) The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that each SAP contains a rationale for its selection that is specific enough for the reader to determine that it was practical and functional for that individual (S1). • Ensure that each SAP has an individualized plan for maintenance and generalization that is consistent with the definition below (S1) • Track engagement across all treatment areas, review trends, and establish acceptable levels of engagement in each treatment area (S1) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data (S3) • Track SAP integrity measures, establish minimal frequencies of integrity measures, establish minimal acceptable treatment integrity levels, and demonstrate that those frequencies and levels are achieved (S3) • Establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3)

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision required an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SGSSLC. As detailed below, more work needs to be done at the facility to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at SGSSLC had multiple skill acquisition plans (SAPs). As indicated in past reviews, SAPs were written and monitored by QDDPs (qualified developmental disabilities professionals). As of September 2012, however, the facility had established the new Program Resources department to reorganize the writing, training and monitoring of SAPs. At the time of the onsite review, SAPs were beginning to be written by six program developers, and monitored by three program trainers. The QDDP Coordinator supervised the program developers and trainers. SAPs continued to be implemented by direct care professionals (DCPs). An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. Forty-two SAPs across 10 individuals were reviewed to determine if they appeared to be functional and practical. In 26 of the 42 SAPs reviewed (62%), the rationale appeared to be based on a clear need and/or preference. This represented a substantial improvement in the percentage of SAPs judged to be practical and functional from the last two reports (16% and 39%). Examples of rationales that were specific enough for the reader to determine if the SAP was practical and functional for that individual were: • The rationale for Individual #64's SAP of safe eating stated, "…he enjoys eating out and likes many foods. Training is to teach him how to eat safely without assistance so that he will not require a modified diet." • The rationale for Individual #48's SAP for pedaling an exercise bike was "…her weight is at high risk and encouraging exercise is important for her optimal health…" As discussed in the last report however, many of the rationales appeared generic; stating that the particular SAP was chosen because the individual wanted to learn the skill.	Noncompliance

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		These rationales were not specific enough for the reader to determine if it was practical and functional for the individual. For example: • The rationale for Individual #304's SAP of writing letters was that her PFA determined that she wanted to learn to write letters. The monitoring team cautions the facility to avoid attempting to address the need to demonstrate that SAPs are practical and functional by simply stating that individuals want to acquire the targeted skill. Rather, the facility should ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual. The rationale for every SAP does not have to be the individual's preference. It can also be based on a need as in the example of Individual #48's rationale. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology As discussed in the last report, the SAP training sheets reviewed consistently contained all of the above components, except for a plan for maintenance. Only three of 42 SAPs reviewed (7%) contained a plan for maintenance. This compares to the last report when 9% of SAPs reviewed contained a plan for maintenance. All skill acquisition plans should include all of the above components. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of	

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		formal training. Thirty-five of the 42 SAPs reviewed (83%) contained a plan for generalization consistent with the definition above. This represented another substantial improvement from the last review when 38% of all generalization plans were consistent with the above definition. An example of a good plan for generalization was: • The plan for generalization in Individual #252's SAP for baking stated that she should "…use her baking skills when on home visits, and when watching a cooking show staff could also go over the steps of the program while watching." An example of a plan for generalization that was not consistent with the above definition, and therefore was unacceptable, was: • The plan for generalization in Individual #60's SAP of taking his medication stated, "He should obtain medication without refusals." The three SAPs that contained maintenance plans were not consistent with the above definition. For example: • The plan for maintenance in Individual #50's SAP of learning community skills stated, "Anytime (Individual #50) crosses the street, present the opportunity for him to maintain his skill at all times." As discussed in the last report, this sounds more like a plan for generalization of skills. An example of a plan for maintenance for Individual #50 would be: • After mastering community skills and the termination of the SAP, he will continue to be requested to independently use community skills in order to maintain this skill. It is recommended that all SAPs contain individualized generalization and maintenance plans that are consistent with the above definitions. At the time of the onsite review, the facility was using the Murdoch Center Foundation skill acquisition system. This system consisted of task analyses, forward and backward chaining instruction, and a self-graphing data procedure. As discussed in the last report, implementation of these SAPs indicated that much more training and monitoring of SAPs at SGSSLC was necessary (see S3). <u>Desensitization skill acquisition</u> As discussed in the last report, the psychology department had recently developed an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) was then developed. Two dental desensitization plans	

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		were written since the last review. A review of those dental desensitization (i.e., Individual #236 and Individual #130) indicated that they appeared clinically sound, however, they did not include all of the components identified as necessary for a SAP (see detailed description of those components above). It is recommended that dental compliance and dental desensitization plans be incorporated into the new SAP format. Additionally, the section S Benchmark Analysis data indicated that these dental desensitization plans were not being consistently implemented. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail in future site visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> SGSSLC continued to include replacement/alternative behaviors in each PBSP. Several of the PBSPs reviewed (e.g., Individual #41) included replacement behaviors written as SAPs (see K9). The format of these replacement behavior SAPs, however, was different then the new SAP format used by the facility. It is recommended that replacement behavior SAPs be written in the same format as other facility SAPs. <u>Communication and language skill acquisition</u> Several of the replacement behavior SAPs targeted the enhancement or establishment of communication and language skills. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs (also see section R). <u>Service objective programming</u> The facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). These were also written and monitored by the QDDPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see provision F for a review and discussion of service objectives). <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at SGSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at	

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		that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program are listed in the table below. The monitoring team noted several age appropriate and typical activities at SGSSLC. Consequently, in several homes visited, the individuals were out of the homes, engaging in activities in the community, or on campus (e.g., gym). Many of the individuals not engaged in these organized activities, however, appeared to be aimlessly roaming about the homes, or lying in bed. The monitoring team did, however, observe some examples of individuals actively engaged in small group activities (e.g., Home 502), however the majority of homes did not appear to have organized activities occurring. When the DCPs were asked why there did not appear to be organized activities in these homes, they consistently responded that the individuals refused. The monitoring team also observed engagement in day programs. As noted in the last review, the engagement in the day programs was generally good, however, it only represented a small number of the individuals at the facility. The majority of individuals at SGSSLC appeared to be on campus or in their homes during the day. For example, the SAP/cultural services (semester program) attendance data indicated that Individual #371 attended day programming 20% of the time, and Individual #215 attended day programming 25% of the time. It is recommended that all individuals be actively engaged in meaningful day programing. The table below documents engagement in various settings throughout the facility. The average engagement level across the facility was 49%, considerably below that observed during the two previous reviews (i.e., 72% and 71%). An engagement level of 75% is a typical target in a facility like SGSSLC, indicating that the engagement of the individuals at SGSSLC continued to have some room to improve. As recommended in the last report, engagement data were now collected by the facility and shared with managers responsible for improving engagement. October 2012's facility collected engagement data was 64%, showing a decreasing trend over the last three months. These decreasing trends in engagement in both the facility's and the monitoring team's data were discouraging. SGSSLC, however, recently developed a PIT to address these decreasing trends in engagement and the low numbers of individuals participating in day programming. The monitoring team was encouraged by this new focus on engagement at SGSSLC, and looks forward to seeing improved engagement at the next onsite review. As noted in section E, the self-advocacy committee might be asked to participate in this PIT and/or the development of other solutions to this	

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		problem. At this point it is recommended that engagement targets for each home and day program be established, and sites with low engagement provide plans for improvement. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
501	4/4	2:4
501	0/1	0:1
516 E	3/10	2:10
510 A	0/6	1:6
510 B	1/2	0:2
510 B	0/2	0:2
510 B	1/1	1:1
Suzy Crawford Center	5/7	3:7
Suzy Crawford Center	3/7	3:7
Suzy Crawford Center	3/6	2:6
Imagination Center	4/4	2:4
Vocational Workshop	6/10	5:10
505 B	1/3	2:3
505 A	1/2	2:2
511 B	2 /4	3:4
511 A	0/2	1:2
Gym	5/5	1:5

<u>Educational Services</u>
SGSSLC maintained a very good relationship with the local school district, the Water Valley Independent School District (WISD). This was evidenced in reports from the WISD special education teacher, the SGSSLC liaisons, minutes from meetings between SGSSLC and WISD, and copies of emails between the special education teachers (at WISD campus and at the SGSSLC campus) and SGSSLC staff. The SGSSLC liaisons were Vicki Hinojos, the residential director, and Michael Davila, QDDP Coordinator. Mr. Davila was recently re-appointed as co-liaison.

Six individuals received educational services from WISD. Two were at the WISD campus and four at the SGSSLC campus. One of these four attended half day in class and half day in vocational training. No students had graduated since the last onsite review (which, coincidentally, occurred at the end of the previous academic year).

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		As recommended in previous reports, about two dozen facility staff received an inservice regarding special education laws. This was great to see. Unfortunately, the QDDP who was now assigned to five of the six students did not attend this training. The new home manager also had not had this training. Both of these staff should now receive this training, too. The facility had discontinued, but now planned to re-initiate, observation and monitoring at both classrooms. This was acceptable to the WISD administration and teachers. The SGSSLC classroom was now in a much better building and room. This new space was clean, bright, spacious, and a much more inviting educational environment compared to where they were for the past few years. The facility administration made this possible. The WISD teacher had made some improvements to the educational program. One was to divide the day into eight periods, just as was done at the WISD campus. As the SGSSLC liaisons begin to spend more time in the classroom, here are some aspects of the classroom program for them to consider as they have discussions with the teacher: • During the monitoring team's observation, the three students were watching TV. It was the Price is Right show, which the teacher described as being related to math and money skills, however, the monitoring team did not observe any instruction going on during or after the TV show. • Physical education consisted of an exercise video of walking. Perhaps actual walking could be considered. • The teacher described using the Firelight reading curriculum. It might be helpful for facility staff to understand how reading is being taught, so that they can help the students during the evening and weekend hours, too. • There were three students in the classroom. There was one WISD classroom teacher, one WISD classroom aide, and two SGSSLC staff. That is, there were four adults for the three students. This was an incredible opportunity for the students to receive intensive educational instruction, especially given the few years left for them to receive educational services. Report cards and progress reports were issued every six weeks. These should be reviewed. A special IDT ISPA meeting will most likely not be required for this (unless there are problems that need to be addressed). The QDDP and liaisons should not be hesitant to ask the classroom teacher if they have questions about how grading was determined, such as what tests, reports, or performance was demonstrated. Three ISPs were reviewed. Two were for the two students who were new admissions, so there was not much detail. One had the wrong individual's name throughout the ISP.	

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		This error should be corrected. Each of the ISPs stated that the individual attended public school, but there did not appear to be any attempt to incorporate what the individual was learning in school into his or her home programming. There were numerous interesting and varied educational objectives in the IEP. These should be considered during the development of the ISP and included as action plans and/or SAPs.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	SGSSLC conducted annual assessments of preference, strengths, skills, and needs. This item was rated as being in noncompliance because, at the time of the onsite review, it was not clear that assessments were consistently used to develop SAPs. SGSSLC completed the transition from the use of the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). The SGSSLC also used a vocational assessment, and the personal focus assessment (PFA) to assess preferences. To assess compliance with this item, the monitoring team reviewed five FSAs, five PFAs, and four vocational assessments (Individual #64 did not have a vocational assessment). The FSA appeared to be an improvement over the PALS in that it provided more information (e.g., necessary prompt level to complete the skill) regarding individual's skills. No assessment tool, however, is going to consistently capture all the important underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be donned, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there are considerable data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed.	Noncompliance

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		Additionally, review of ISPs and assessments did not consistently document how assessments impacted the development of programs. The following were typical: • Individual #41 had a SAP to add coins, however, her FSA indicated that she was independent in adding coins. There was no explanation in her ISP or FSA as to why she should have a SAP for a skill that she already possessed. • Individual #48 had a SAP to learn how to do her laundry, however, her FSA stated that she was able to independently do her laundry. • Individual #123 had a SAP for money management that indicated that he wanted to learn to manage his money, however, there was no documentation in his ISP or PFA that he wanted to manage his money. • Individual #163 had a medication SAP, but no mention in her ISP of any assessment results (e.g., FSA or PSA) that suggested that this was a practical SAP for her. The facility should ensure that assessments are consistently used and documented to select individual skill acquisition plans.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	SGSSLC needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity, before this item is rated as in substantial compliance. QDDPs at SGSSLC summarized SAP data monthly. As reported in the last review, however, the monitoring team was not provided with any evidence that monthly SAP outcome data were graphed. The QDDPs simply noted if there was progress, or not, in each month. It is recommended that a measure of progress (e.g., the level of prompting necessary, or number of steps in the task analysis completed) be graphed monthly for each SAP to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs. The monitoring team's visual inspection of monthly SAP data revealed that skill acquisition plans were producing behavior change for 11 of 38 SAPs	Noncompliance

#	Provision	Assessment of Status	Compliance
		(four SAPs did not contain outcome data) reviewed (29%). This represented an improvement from the last report when 3% of SAPs reviewed were judged to be producing a positive behavior change. It is recommended that the facility ensure that decisions concerning the continuation, discontinuation, or modification of SAPs are based on outcome data. As reported in the last review, staff appeared to continue to struggle with the Murdoch procedure. For example: • The monitoring team observed the implementation of Individual #97's SAP of dialing the phone. The SAP indicated that the methodology used was forward chaining. The staff, however, were confused if forward chaining required physical guiding through all of the steps of the task analysis, or just the training step. • Seventeen of the 38 SAP data sheets reviewed (45%) did not appear to be correctly implemented. The only way to ensure that SAPs are conducted as written, however, is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. In September 2012 the program trainers began training DCPs in the implementation of SAPs. Additionally, as recommended in the last review, the program trainers had begun to collect SAP integrity checks. The monitoring team looks forward to learning of the affects of this new position on the integrity of SAPs at SGSSLC. Finally, the monitoring team also reviewed SAP data sheets to evaluate if data were completed as scheduled. All four SAP data sheets reviewed (100%) documented the training of SAPs as specified in the SAP schedule. This was consistent with the last review when 100% of SAPs reviewed in the homes were completed as scheduled.	
	(b) Include to the degree practicable training opportunities in community settings.	The majority of individuals at SGSSLC participated in various recreational activities in the community, and some were provided training opportunities in the community. In order to achieve substantial compliance with this provision item, the facility now needs to establish acceptable levels of activities and training in the community, and demonstrate the that those levels are consistently achieved. As discussed in the last review, the facility began a new tracking of leisure activities and training of SAP objectives in community activities. The documentation revealed several instances of training of SAPs in the community that ranged from 5% to 18% of community trips from June 2012 to October of 2012. The QDDP Coordinator indicated that the facility was developing a plan to increase those percentages of community trips	Noncompliance

#	Provision	Assessment of Status	Compliance
		that include SAP training. It is recommended that the facility now establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved. At the time of the onsite review, two individuals at SGSSLC had supported employment in the community. This represented the slightest of an increase from the last onsite review when one individual had supported employment in the community.	

Recommendations:

1. Ensure that the rationale for the selection of each individual's SAPs is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).
2. All SAPs should contain individualized generalization and maintenance plans that are consistent with the above definitions (S1).
3. Dental compliance and dental desensitization plans should be written in the new SAP format (S1).
4. Ensure that dental desensitization plans are being consistently implemented (S1).
5. Ensure that replacement behavior SAPs are written in the new SAP format (S1).
6. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs (S1).
7. Ensure that all individuals are engaged in meaningful day programming (S1).
8. Engagement targets for each home and day program should be established, and sites with low engagement should provide plans for improvement (S1).
9. Provide training on special education laws to the new QDDP and home manager (S1).
10. Incorporation the IEP into the ISP, as appropriate, via action plans and/or SAPs (S1).
11. Review WISD progress reports and report cards (S1).
12. Ensure that assessments are consistently used and documented to select individual skill acquisition plans (S2).
13. A measure of progress should be graphed monthly for each SAP to improve data based decisions regarding the continuation, modification, or discontinuation of SAPs (S3).

14. Ensure that SAPs are implemented with integrity (S3).

15. The facility should establish acceptable percentages of individuals participating in community activities and training on SAP objectives in the community, and demonstrate that these levels are achieved (S3).

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, attachments, January 2012 o SGSSLC facility-specific policies regarding most integrated setting practices • Continuity of Services, 2.1.01, updated 4/19/12 • Most Integrated Services, 2.1.31, 4/29/11 o SGSSLC organizational chart, undated o SGSSLC policy lists, 5/25/12 o List of typical meetings that occurred at SGSSLC, (not provided) o SGSSLC Self-Assessment, 11/19/12 o SGSSLC Action Plans, 11/16/12 o SGSSLC Provision Action Information, most recent entries 11/16/12 o SGSSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/4/12 o Admissions/Placement dept. QA benchmark meeting summaries, August 2012 to November 2012 o Admissions/Placement dept. QA report section, once, October 2012 o Quality assurance department presentations to QI Council, once, 10/30/12 o APC notations on previous monitoring report o Community Placement Report, last six months, 6/1/12 through 12/1/12 o List of individuals who were placed since last onsite review (18 individuals) o List of individuals who were referred for placement since the last review (18 individuals) o List of individuals who were referred <u>and</u> placed since the last review (1 individual) o List of total active referrals (23 individuals), as of 12/8/12 o List of individuals who requested placement, but weren't referred (17 individuals) • Documentation of activities taken for those who did not have an LAR (9 individuals) • Those who requested placement, but not referred due to LAR preference (8 individuals) o List of individuals who were not referred solely due to LAR preference (no data) o List of rescinded referrals (4 individuals) • ISPA notes regarding each rescinding (3 of the 4) • Special Review Team minutes for each rescinding (0) o List of individuals returned to facility after community placement (4, plus 2-3 more pending) • Related ISPA documentation (2) • Root cause analysis report form (2) o List of individuals who experienced serious placement problems, such as being jailed,

	psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement, and a brief narrative for each case (8 of 25 individuals who moved since 11/1/11, i.e., 1 year since placement) • Graphs of the above data o List of individuals who died after moving from the facility to the community since 7/1/09 (3 individuals, 0 since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (2 individuals) o Graphs of most integrated setting related data, November 2012 o APC weekly reports • Statewide weekly enrollment report (9/12/12-9/28/12) • Detailed referral and placement report for senior management (none) o Job descriptions for APC, PMM, and transition specialists o APC Department meeting email for September 2012 and October 2012 o Transition Committee meeting minutes, usually weekly, 6/26/12 through 11/27/12 o Most integrated setting workgroup minutes, July 2012-November 2012 (5 meetings) o Summary table and graphs about obstacles in the ISP, thorough November 2012 o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, September 2012 ▪ Announcements, attendance sheets, evaluation information, and summaries • Community tours, 6/4/12 through 12/3/12 (16 for 87 individuals, some more than once) ▪ ISPA notes (or other documentation for all) • Meetings/trainings with local LA (2), 11/16/12, 8/29/12, 8/31/12 • New employee orientation (none) • Sessions with facility staff: (1) QDDPs, 9/26/12 • Self-advocacy meeting (2) 8/14/12, 10/9/12 • Family association meetings (none) • Facility newsletter, information on admission and placement (none) • CLOIP and Permanency Plan tracking sheets, September 2012 through November 2012 o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred), obstacles were not included, undated o List of individuals who had a CLDP completed since last review, 6/8/12-10/31/12 (16 individuals) o Completed checklists used by APC regarding submission of assessments for CLDP that were <u>not</u> within the CLDP, and completed checklists (none) o ENE support four part spreadsheet (two) o DADS central office written feedback on CLDPs (five) o For the three statewide monitoring tools for section T: (Living options-4, CLDP-?, Post move monitoring-?, and ? inter-rater reliability tools. Could not determine the total number from various spreadsheets) o State obstacles report and SSLC addendum, October 2011

	o Obstacles spreadsheet, undated, 19 pages o PMM tracking sheet, 12/6/12 o Transition T4 materials for: • Individual #197, Individual #249 o ISPs and assessments in the older styles for: • Individual #271, Individual #196, Individual #379, Individual #255, Individual #123, Individual #163, Individual #60, Individual #99, Individual #223, Individual #207, Individual #130, Individual #50 o ISPAs regarding living options discussions for: • (none) o ISPs in the November 2012 style for: • (none) o CLDPs for: • Individual #12, Individual #41, Individual #64, Individual #353, Individual #184, Individual #177, Individual #19, Individual #313, Individual #119, Individual #292, Individual #330, Individual #352, Individual #248, Individual #93, Individual #143, Individual #274 o Draft CLDP for: • (none) o In-process CLDPs for: • Individual #252, Individual #396, Individual #300 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #230: 90 • Individual #309: 45, 90 • Individual #75: 45, 90 • Individual #81: 45, 90 • Individual #55: 7, 45, 90 • Individual #262: 7, 45, 90 • Individual #274: P, 7, 45, 90 • Individual #143: P, 7, 45, 90 • Individual #247: P, 7, 45 (returned to facility prior to 90) • Individual #93: P, 7, 45, 90 • Individual #248: P, 7, 45 (returned to facility prior to 90) • Individual #330: P, 7, 45, 90 • Individual #352: P, 7, 45 (returned to facility prior to 90) • Individual #292: P, 7, 45 • Individual #19: P, 7, 45 • Individual #313: P, 7, 45 • Individual #119: P, 7, 45

	• Individual #184: P, 7, 45 • Individual #353: P, 7 • Individual #177: P, 7 <u>Interviews and Meetings Held</u>: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post Move Monitor; James Reid, Janet Jordan, Facility Transition Specialists; Donnie Varela, Transition Specialist o Roy Smith, Human Rights Officer, Zula White, Human Rights Assistant, and Melissa Deere, Assistant Independent Ombudsman o Unit Directors: Cedric Woodruff, Tricia Trout, Mandy Rodriguez o Lettitia McPherson: ARC of San Angelo, Guardianship Alliance <u>Observations Conducted</u>: o CLDP Meeting for: • (none) o CLDP assessment review meeting for: (none) o ISP Meeting for: • Individual #48, Individual #127 o ISP preparation meeting for: • (none) o Community group home visit for: • (none) o Self-advocacy meeting, 12/4/12
	Facility Self-Assessment The self-assessment remained the same as during the last review. The APC self-rated T1c1, T1c2, T1c3, T1d, T1e, and T2a in substantial compliance. The monitoring team agreed with four of these (T1c2, T1c3, T1d, T2a). The difference in T1c1 and T1e were that the APC relied primarily, if not solely, upon the statewide self-monitoring tools. These tools did not capture all of what the monitoring team looks at when conducting the six-month monitoring reviews. The APC reported that the way the self-assessment was to be conducted, and the way self-monitoring for section T was to be conducted, were going to be changing. This was going to occur under the direction of the state office discipline coordinator. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and believes that the facility was continuing to proceed in the right direction (i.e., attempting to conduct a self-assessment, though a new tool and a new process for self-assessment was needed. An improved self-assessment will also lead to a better set of action plans.

	Summary of Monitor's Assessment SGSSLC continued to make progress across all of section T. The specific numbers of individuals who were placed and who were in the referral and placement process had increased to 16% of the total census. Approximately 10% of the individuals at the facility were on the active referral list. 18 individuals were placed in the community since the last onsite review. This was the highest number of placements during any six month period since monitoring began. Unfortunately, of these 18 placements, 3 individuals had severe problems in the community and had already returned to the facility. The placements of 2 others were reported to be unstable and a return to the facility likely. A total of 4 individuals were returned to the facility after community placement, and a fifth was expected in the week following the onsite review. A root cause analysis was conducted for two individuals, however, it did not provide the facility with direction to improve or change any current practices. Item 4 of the RCA form asked about what could be done to avoid future occurrences, but the responses give were for the case at hand only. Some of the problems identified by the RCA were already well known to the APC and transition specialists. Of the 20 individuals who received post move monitoring, 12 (60%) were maintaining successfully or fairly successfully in the community. Of these 12, however, 5 had serious events occur during their first 90 days in the community. So, even though they were doing OK at the time of their most recent post move monitoring, it was not without problems and incidents that were far beyond what one might expect as a normal part of a transition and severe enough that they might have resulted in a return to the facility. Of these 12, 1 was arrested and jailed, 3 were hospitalized in a psychiatric hospital, 2 were prescribed psychotropic medications they hadn't been receiving while at SGSSLC, and 1 had to change homes (some individuals had more than one of these untoward outcomes). Thus, of the 20, only 7 (35%) had transitions that went as the IDT, for the most part, expected. Of the other 8 individuals (40%) who received post move monitoring, 5 had returned readmitted to the facility, 1 was likely to soon return to the facility, and the other two remained unstable in their placement. More should be done when supports are not implemented, not implemented correctly, and/or if there are problems in the placement. Some new activities were occurring regarding placement and transition: the plan for creation of a transition home, initiation of a most integrated setting practices workgroup, and a regular monthly meeting of the APC and his staff. Eight of the 16 CLDPs (50%) were developed in a timely manner. That is, activities related to transition and placement occurred at a good pace for half of the CLDPs. For the others, there were long lapses (many months) during which there was little or no indication of the reason for the absence of activity. A CLDP meeting was not held during the week of the onsite review. Therefore, one could not be observed.

	IDT members continued to be very involved in the placement activities of the individuals. Team members thoughtfully evaluated the homes and day programs being explored by the individual. Changes to improve the quality of the discharge assessments were not done as recommended in the previous report. Primarily, the APC and transition specialists were not ensuring that the discipline recommendations were correct and thorough. and designed for the new environments. Surprisingly, there were no psychiatry discharge assessments done for any of the individuals. This should occur for those individuals who received psychiatry services at SGSSLC. SGSSLC continued to make incremental progress in developing thorough comprehensive ENE support lists. Section T1e details this and focuses on a number of areas, including histories of behavioral and/or psychiatric problems, rewards and other aspects of PBSPs, health, employment, skills and activities, and implementation by provider. Since the last review, 43 post move monitorings for 20 individuals were completed. The post move monitoring report forms were completed correctly and thoroughly. Good information was included.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of	SGSSLC continued to make progress across all of section T. This was due, in large part to the leadership provided by the APC, Tim Welch, and his experienced transition specialists, James Reid and Janet Jordan, and by his experienced the post move monitor (PMM), Denise Copeland. In addition, one new state office transition specialist position was created and filled brining the total admissions and placement department staff to a total of five FTEs. Further, the APC responded to the comments, suggestions, and recommendations in the previous monitoring report. The specific numbers of individuals who were placed and who were in the referral and placement process had increased to 16% of the total census. Approximately 10% of the individuals at the facility were on the active referral list, about the same percentage as during the last review. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 18 individuals were placed in the community since the last onsite review. This compared with 12, 13, 10, 10, and 17 individuals who had been placed during the periods preceding the previous reviews. o This was the highest number of placements during any six month period since monitoring began. Unfortunately, of these 18 placements, 3 individuals had severe problems in the community and had already returned to the facility. The placements of 2 others were reported to be	Noncompliance

	the State, the resources available to the State, and the needs of others with developmental disabilities.	unstable and a return to the facility likely. • 18 individuals were referred for placement since the last onsite review. o This compared with 12 and 23 who were newly referred at the time of the previous reviews. o 1 of these 18 individuals was both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals (i.e., at an annualized rate of 16% of the census). • 23 individuals were on the active referral list. This compared with 27, 33, 27, 21, and 19 individuals at the time of the previous reviews. o This was a relatively stable number and indicated that the admissions and placement department had a lot of work to do over the next six months. o 6 of the 23 individuals were referred for more than 180 days. ▪ 1 of the 6 was referred more than one year ago. • 17 individuals were described as having requested placement, but were not referred. This compared with 13, 27, 21, 44, and 80 individuals at the time of the previous reviews, respectively. o 8 were not referred due to LAR preference. o 2 were not referred due to legal reasons. o For the remaining 7, documentation was submitted providing detail of the lack of consensus review (described in the previous report). Further, the situation for one individual described in the previous report was resolved (regarding there not having been an updated PBSP for Individual #258). • The list of individuals not being referred solely due to LAR preference contained 67 names (compared to 1, 12, 5, and 8 individuals at the time of the previous reviews, respectively). o This list was done incorrectly. It should be a listing those individuals who would have been referred by the IDT, but were not solely due to LAR preference. Instead, it was a listing of individuals who were not referred and who had an LAR (regardless of whether the IDT would or would not have otherwise made a referral). o The APC reported that he believed when this list is done correctly there will be no individuals on this list. The monitoring team believes that this will not be the case (e.g., perhaps Individual #318 will be on this list). • The referrals of 4 individuals were rescinded since the last review. This compared to 9, 2, 3, 5, and 4 at the time of the previous reviews. o Documentation was provided for 3 of the 4 individuals regarding the reasons for the rescinding, including ISPA notes.	

		○ All 4 were due to behavioral problems (though Individual #162 also stated that she no longer wanted to be referred). ○ The APC should do a detailed review (i.e., root cause analysis) of each of these rescinded cases to determine if anything different could have been done during the time the individual was an active referral. The purpose of the APC review is to assess the referral and placement processes. ○ Note that the new ISP process may result in an increase in referrals and, as a result, an increase in the number of rescinded referrals. If this occurs, it should not necessarily be viewed as an increase in failure by the facility. • 4 individuals were returned to the facility after community placement, and a fifth was expected in the week following the onsite review (Individual #247, Individual #55, Individual #352, Individual #81, Individual #248). This compared with 0, 2, 0, and 1 individuals at the time of the previous reviews. ○ This was by far the highest number of failed placements since monitoring began. ○ In addition to these five individuals, the placements of two others were described as being unstable and a return to the facility a likely possibility (Individual #353, Individual #184). ○ These failed (and failing) placements indicated problems in a variety of areas regarding transition and placement, including, but not limited to, ▪ transition planning by the facility, ▪ the CLDP, ▪ community provider capability, ▪ availability of community clinical services, and ▪ community emergency support. ○ An ISPA and a root cause analysis were submitted for Individual #247 and Individual #55, and a special review team report was also submitted for Individual #247. ISPAs, SRTs, and RCAs were not submitted for the other three individuals who returned to the facility. The monitoring team, however, surmises that the same issues (described below) applied to these cases, too. ▪ The ISPA, SRT, and RCA reviewed addressed issues specifically related to these two individuals. Thus, there was good consideration and reflection on what went wrong for the individual. ▪ The RCA analysis, however, did not provide the facility with direction to improve or change any current practices. Item 4 of the RCA form asked about what could be done to avoid future occurrences, but the responses give were for the case at hand only. Thus, no changes in practice resulted from this RCA exercise. During the previous review, the monitoring team was	

encouraged by the RCA conducted for a failed placement. It appeared, however, that this was not moved forward and the completion of the SRT and RCA had, unfortunately, become nothing more than a paperwork bureaucratic activity.

- More disheartening was that some of the problems identified by the RCA were already well known to the APC and transition specialists. Thus, it was surprising that they had not been addressed adequately during the planning processes. The APC and transition specialists do this work every day. IDTs and QDDPs do not. Therefore, even though IDTs and QDDPs will benefit from additional training, it will be the responsibility of the APC and his staff to ensure these issues are addressed during CLDP development and transition planning activities. Consider the following.
    - The RCA for Individual #55 noted that elopement was noted in her BSP, but not included in the training for the provider staff. For Individual #247, the report merely stated that his team didn't think he'd have serious behavioral issues and that all of this was addressed in his PBSP, however, the only requirement of the provider was that they had a copy of PBSP in the home and that staff appropriately responded when interviewed by the PMM.
        - These two issues were raised in every previous monitoring report. First, the importance of addressing serious histories of problem behaviors even if they had not occurred at the facility in a long time cannot be overstated. Second, there was nothing required of the provider regarding implementation of the many aspects of a PBSP that can reduce the likelihood of a behavior problem occurring in the first place. Also see T1e below.
    - The report noted that provider did not adequately train staff or properly staff his group home, whereas the provider and the parents had a different opinion and noted that the facility had not adequately prepared the individual and the provider.
    - Apparently, during the CLDP, the facility and provider agreed to remove some of his staffing supervision requirements (e.g., two staff, mostly male). Again, this

		was done without taking into account the individual's history of challenging behaviors. Consider that this individual also exhibited behavior problems during his trial visits. • He never went to paid work after moving, only to day hab. Earning money was very important to him, especially to purchase cell phone time and cigarettes (these eventually became issues that led to major behavior outbursts). o Problems with individuals not fully understanding what it means to not have paid work and money was raised as a problem in a number of previous monitoring reports. • If the IDT feels it is being pressured for placement to occur before the team members feel is appropriate, the APC must take the lead and go to the facility director for support. o The monitoring team fully understands that the facility placed and will continue to place individuals with challenging histories and complex needs. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, who had run away from their community placements, and/or had other untoward incidents continued to be tracked, recorded, and graphed. This was good to see. These data were now being obtained for at least a one-year period after moving. o The APC kept a spreadsheet of all individuals who moved during the previous 12 months, and he kept separate spreadsheet with 7 columns for each type of untoward event, and he kept a table with detail on each of these 7 types of events. o Of the 24 individuals who moved in the past 12 months, 9 were reported to have one or more untoward events (38%). o The APC should do some sort of analysis or review of each of these situations to, once again, learn what might be improved in the CLDP and transition planning process. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, transition specialists, and PMM. • 0 individuals had died since being placed since the last onsite review. This compared with 1 at the time of the previous review. o A total of 3 individuals had died since 7/1/09. • 2 individuals were discharged under alternate discharge procedures. This	

		compared with 1 at the time of the previous review (see T4). As recommended in previous monitoring report, the APC improved the way he graphed the above bullets. This was good to see and should be useful to the APC in his review and presentations of his department's activities and progress in the benchmark meetings, QA report, and QI Council. Not all of these data/graphs were submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team suggests that APC add to his set of graphs so that he has a full set of relevant graphs. A list of suggestions is provided below. The printouts can have more than one small graph on each page (e.g., three or four) to make the set of graphs easier to manage for the reader. • Number of individuals placed each month (done) • Number of new referrals each month or six-month period (done) • Number of individuals on the active referral list as of the last day of each month (done) • Number of individuals on the active referral list for more than 180 days, as of the last day of each month (not done) • Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers) (not done) • Number of individuals who have requested placement, but have not been referred, as of the last day of each month (done) • Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month (not done) • Number of individuals not referred solely due to LAR preference as of the last day of each month (done, but as noted above, the data were incorrect). • Number of individuals who had any untoward event happen after community placement each month (not done) o Cumulative number of each type of untoward event for all placements (done, back to 9/1/11) • Number of rescinded referrals each month or each six-month period (done) • Number of returns from the community in each six-month period (done) • Number of deaths in each six-month period (done) • Number of alternative discharges (T4) (done) • From T1b1 below: number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles • From T1b2 below: number of individuals who went on a community provider tour each month	

		Other activities In the last report, the monitoring team commented on three other activities related to most integrated setting practices. One was the creation of a sections F and T team. This was now discontinued. Second, was the creation of a transition committee. Their work continued and they now asked for a presentation from the IDT at the 90-day mark since referral. The minutes of these meetings indicated good discussion. Third was an ISP support group. This activity also continued. A new activity was the creation of a transition home. The intent was for home 512 (A and B) to made to replicate (as much as possible) a community home in design, schedule of activities, travel into the community, jobs, cooking, laundry, etc. This sounded like a very good idea. It will be managed by residential services under the direction of one of the unit directors. The APC and transition specialists should not miss the opportunity to participate in the development and initial implementation of this specialized program. Another new activity was the creation of the Most Integrated Setting workgroup (though this was not included in the QA department's listing of active workgroups at SGSSLC). This was a forum in which some of the issues addressed in this and previous monitoring reports were discussed, such as problems in securing psychiatric and employment services, and enrolling individuals in the community preparation psychology class. Another activity was the admissions and placement department monthly meeting. Topics on the agendas for September 2012, October 2012, and November 2012 included relevant information, such as items that are mentioned in this, and in previous monitoring reports (e.g., compare the ENE tool to the All About Me files before the CLDP meeting, conducting SRTs and RCAs, including training objectives in the CLDP, include furlough notices in the CLDP). This demonstrated that the APC was taking some action to move the department forward in implement improvements. Determinations of professionals This aspect of this provision item requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. This was discussed at length in previous monitoring reports. Primary responsibility for meeting this requirement belongs to the QDDPs and the professionals. Thus, the monitoring team looks for indications in each professional's assessment, during the conduct of the annual ISP meeting, and in the written ISP that is completed after the annual ISP meeting. SGSSLC was transitioning to the newest iteration of the ISP process (see section F). As a	

		result, the monitoring team was limited in its ability to review professional determinations. During the week of the onsite review, the first new style annual ISP meetings were held (two). The monitoring team observed these meetings. The resultant written ISPs, however, were not completed (they were not due for 30 days after the meeting). As a result, the monitoring team used its observation of these two annual ISP meetings, and a review of a sample of ISP documents completed for 12 annual ISP meetings held in August, September, and October 2012. The monitoring team understands that the content and processes used in these 12 written ISP meetings and documents were to be revised/updated. Nevertheless, the monitoring team provides some comments below and in section T1b1 and T1b3. Overall, status regarding the provision of professionals' opinions had not improved since the last review. First, for the written assessment updates that were attached to the 12 ISPs, the professional's opinion was typically included in the assessments done by nursing, dental, vocational, rehabilitation, and speech and language. Medical often gave an opinion that there were no medical contraindications, but would need to defer to psychiatry and psychology. Unfortunately, there were no psychiatry ISP assessments. Further, the psychology professional typically noted that community living would be recommended if a list of supports were in place. Although this was an important statement, it was inadequate in that the psychologist did not give a determination. It could be that the psychologists needed more information about community services or it could be that the psychologists did not want to give an explicit determination. The psychiatrist and the psychologist's determinations are very important in this process. Also, it appeared that not all assessments were submitted to the monitoring team for each of the sample ISPs. Second, in the ISP meeting and ISP preparation meetings observed during the week of the onsite review, community living was discussed at various times during the meeting. This was good to see (see T1b3). In one of the two meetings, professionals were specifically asked to, and did, give their explicit opinions/determinations. Third, in the monitoring team review of the sample of 12 completed ISPs, there was no explicit description of the discussion of professionals' opinions and determinations. There was, however, discussion of living options in every one of them (see T1b3), including a statement about the IDT's determination. This statement did not, however, convey any of the IDT's discussion, and did not provide the IDT's opinion separate from the preferences of the LAR and/or individual (even though there was a prompt to do so in the ISP form template). Also, for individuals who could not give their own preference, the IDT determined that	

		the individual's preference was to not move. This showed good intent by the IDT, but the monitoring team is not sure that this was the state's intent for that option. The APC should check on this. Overall, the monitoring team found that the written ISP for Individual #123 to be the best of the set of 12 ISPs reviewed. Perhaps not coincidentally, it was the most recent (late October 2012). <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by SGSSLC IDT members. Efforts of the APC, transition specialists, IDT members, the human rights officer and his staff, and the assistant independent ombudsman were evident in all of the most integrated setting practices related activities at SGSSLC. <u>Preferences of LARs and family members</u> SGSSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. <u>Senior management</u> There continued to be no mechanism to provide the kind of detail that senior management should have regarding the status of individuals who were on the referral list. The monitoring team continues to recommend that the APC continued to keep facility senior management well informed of the status of all referrals. A brief weekly oral presentation might be one way to do so. The weekly administrative IDT meeting would be one gathering during which this could occur. The APC said that he attended this meeting each week and planned to use this forum to present community placement referral updates in the future.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. A revision was completed and the DADS state office was expecting to disseminate it very soon. The facility-specific policy was unchanged since the last onsite review and comments from the previous report were still applicable. Implementation of the new state policy will require updating of facility policies to make them in line with the new state policy. Further, at the parties' meetings in July 2012, the parties agreed that the rating for T1b would be based solely on the development of adequate state and facility policies. The sections T1b1 through T1b3 would be considered stand-alone provisions that required implementation independent of T1b or any of the other provision items under T1b.	Noncompliance

		The state and facility had not yet finalized adequate policies related to most integrated setting practices, therefore, the facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The newest style ISP process had been brought to SGSSLC, but was only implemented for the first time during the week of this onsite review. The new ISP was to include items that had been missing from previous ISP formats, such as professional's opinions (T1a), the identification of protections, services, and supports (T1b1), the identification of individual obstacles (T1b1), and a thorough living options discussion and determination (T1b3). <u>Protections, Services, and Supports</u> The reader should see sections F and S of this report regarding the monitoring team's findings about the current status of ISPs and the IDT's ability to adequately identify the protections, services, and supports needed for each individual. Recently, DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was also found for these three provision items of section F: F1d, F2a1, and F2a3 Across the 12 ISPs and 16 CLDPs reviewed by the monitoring team, there were few special actions taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC and/or transition specialist seek out the IDT, and the active treatment coordinator to talk about what SAPs might be considered now that the individual was referred for placement. This should be documented in the CLDP. If this type of discussion occurred during the ISP meeting in which the individual was referred, it should be explicitly documented in the ISP, too. • For individuals who have been referred, there might be an action plan (set of actions, SAPs) directly related to the individual's upcoming move. • Some of the ISPs did indicate some action plans related to moving to the community, such as attending the on campus community preparation semester sessions class (Individual #123), going on more community outings (Individual #60), and learning to have a checking account (Individual #196 [even though she was not referred for placement]). This process, for those who have been referred, would benefit from involvement of the APC and/or transition specialists. • As noted in section F, in planning for moving to the community, activities other than outings should be considered, such as attending church in the community, banking in the community, joining community groups focused on personal individual interests, and exploring volunteer opportunities.	Noncompliance

		Obstacles to Movement Given that a new iteration of the ISP was just underway, the monitoring team's ability to comment on this aspect of this provision item was extremely limited. Going forward, the facility should ensure that obstacles to referral and to placement are appropriately identified and included in the new ISP (the ISP template format included this). Further, there should be an action plan to address whatever obstacle or obstacles were identified. The APC continued the data collection spreadsheet described in the previous report. According to his data (which were only through August 2012), there was an increasing percentage of ISPs in which an obstacle was clearly identified (about 80% over the last three months of data) and a stable percentage of obstacles for which there was a specific plan to address it (about 50% over the past three months of data). The data system, however, was undergoing changes, such as allowing for more than one obstacle to be reported and to separate obstacles to referral from obstacles to placement. The monitoring team recommends that the APC continue with this line of data review, but ensure that what he is measuring is accurate, that is, are obstacles that are identified reasonable based on the content of the ISP and are the plans in place ones that do indeed address the identified obstacles. These data should be included in the APC's QA-related activities, such as benchmark meetings, QA report, and QI Council presentations.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. SGSSLC was engaging in some, but not all, of these activities. Overall, however, progress was demonstrated. 1. Individualized plan • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered o Includes the individual's LAR and family, as appropriate o Indicates if the previous year's individualized plan was completed. SGSSLC status: There was some progress towards developing an individualized plan in that the newer ISPs described activities the individual and/or LAR would take over the upcoming year, such as visiting some community providers, especially in the ISPs conducted since August 2012. The most recent of the ISPs reviewed by the monitoring team had the best, most detailed description that, with some additional structure to the written ISP, came closest to meeting this standard. 2. Provider fair • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers)	Noncompliance

		○ Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs SGSSLC status: The annual provider fair was held in September 2012. Sample questions were provided to help individuals talk with providers, sign in sheets were collected, and an evaluation survey conducted. Data were bar graphed on attendance for the past four years; individual and staff attendance was the lowest in these four years. Recommendations were made by staff and by individuals. During the next onsite review, the APC should report on what he was planning for next year's provider fair and how the data and responses received this year affected what is planned for next year. 3. Local MRA/LA • Regular SSLC meeting with local MRA/LA SGSSLC status: The APC maintained a good working relationship with the local authority. Two meetings occurred since the last review. These were two quarterly meetings (August 2012, November 2012). The APC provided documentation regarding these meetings. The topics were very relevant to most integrated setting practices. The November 2012 meeting was the annual inservice. In addition, the LA held quarterly meetings with local providers and LA staff, such as HCS service coordinators. The transition specialist was invited to these meetings by the LA. 4. Education about community options • Outcomes/measures are determined and data collected on: ○ Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. ○ Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities SGSSLC status: SGSSLC had not yet started to address this activity. The APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the LA CLOIP workers. 5. Tours of community providers • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. SGSSLC status: The APC made further progress since the last onsite review. Even more tour opportunities had occurred (16) compared to the previous reviews (12 and 9). Eighty-seven individuals went on tours (though some of this total may be individuals who went on more than one tour). The APC maintained the spreadsheet	

		described in the last report. Information was now being sent to the IDTs. The staff accompanying each tour wrote a description of individuals' reactions and responses. Some staff wrote a few sentences about each individual separately. This will be more useful to the IDTs than the staff who wrote general statements about the group as a whole. Going forward, this system should next: o Include these data in the QA program and perhaps graph the number of individuals who went on community tours in the set of graphs described in T1a. o Some individuals may have gone on more than one tour. In the data, separate out these totals. A tracking system is needed so that the APC knows if all individuals for whom a tour is appropriate indeed went on a tour. o Try to assess the effects of tours, such as whether tours result in referrals. 6. Visit friends who live in the community SGSSLC status: SGSSLC was not yet implementing this activity in any organized manner. 7. Education may be provided at • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate SGSSLC status: SGSSLC continued to provide a lot of information to individuals, especially via the monthly self-advocacy committee. The new transition specialist attended the monthly self-advocacy committee meeting and had made presentations twice in the last six months. She also organized what were called coffee shop meetings during which staff from one community provider sit at a table with information about their services and supports for individuals and staff. Last month, for example, she reported that 11 individuals talked with staff from Daybreak. She plans to have different providers each month. The APC, transition specialist, and human rights officer might consider also taking advantage of the weekly meetings that occurred on each home. To that end, they might talk with the unit directors about where it might make sense to conduct a presentation and discussion about community living. 8. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals SGSSLC status: Another training session for QDDPs was held since the last onsite	

		review. The new transition specialist conducted the most integrated setting practices portion of new employee orientation and she was assigned to work with each IDT one by one (17 teams), though this had not yet started and it was unclear as to what her exact responsibilities and goals would be with each IDT. There were no other training or educational plans for other management, clinical, or DSP staff. As mentioned in the previous report, the facility might consider a standard set at one of the other SSLCs: newly hired QDDPs were expected to attend a community tour within their first six months of employment and all IDT members were expected to go on at least one community tour each year. Providing more information to senior management, as noted in T1a, might also help the facility work towards meeting this aspect of this provision item. <u>9. Individuals and families who are reluctant have opportunities to learn about success stories</u> • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition <u>SGSSLC status</u>: The APC was not yet implementing this activity.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The APC presented the procedures that would meet this requirement (i.e., what is also described in T1a regarding professional determinations), however, as noted in T1a, this was not yet occurring regularly. To meet substantial compliance with this provision item, the facility will need address the following four items to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual written assessments. o This was not being done across all disciplines. Further, some disciplines were not providing a clear determination and opinion (e.g., psychology). • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting. o This was occurring at some, but not all of the living option discussions at SGSSLC. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o There appeared to be progress in this area. o There was no indication of any living options discussions occurring in between regularly scheduled annual ISP meetings (there may not have	Noncompliance

		been any, but if there were, this should be captured by the APC). • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR o Although there were statements at the end of the ISP, in a section titled Living Option Determination, these were not yet written adequately or in enough detail. o Many of the Living Option Determination sections merely said that the IDT was following the LAR's preferences. More detail should be included in the Living Option Determination section of the ISP, so that the reader has a good understanding of the IDT's opinion and how it was arrived at.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted 16 CLDPs completed since the last review. This was 100% of the CLDPs completed since then. The monitoring team reviewed a sample of these in detail. A set of in-process CLDPs was also reviewed. <u>Timeliness</u>: Eight of the 16 CLDPs (50%) were developed in a timely manner. That is, activities related to transition and placement occurred at a good pace for half of the CLDPs. For the others, there were long lapses (many months) during which there was little or no indication of the reason for the absence of activity. Most of these individuals had been referred more than a year prior to placement. Currently, only 1 individual on the active referral list was referred more than a year ago. It may be that the APC, his staff, and the IDTs focused on these longer-term referrals and the problems in the CLDPs being timely will no longer be a problem. The APC did not continue to chart the length of time of referral as he had been doing at the time of the previous review. <u>Initiation of the CLDP</u>: Rather than waiting until right before the individual moved, the CLDP document was now created at the time of referral. This occurred regularly at SGSSLC, usually at a meeting called the APC-PMM-IDT meeting. This typically occurred at the ISP meeting (if a referral occurred then) or within a week or so after the referral. The CLDP contents were then developed and completed over the months during which referral and placement activities occurred. A sample of three in-process CLDPs was reviewed. They were for referrals that occurred approximately 30, 90, and 120 days ago. The APC or the transition specialists entered all information into these CLDPs. There was not much information in any of the CLDPs. Although the APC was hoping for there to be more development of CLDPs by IDTs and	Noncompliance

		QDDPs, the monitoring team believes that, for the foreseeable future, the transition specialists will need to be the lead in ensuring the CLDPs are developed timely, thoroughly, and correctly. For the next onsite review, the monitoring team would appreciate a detailed presentation of the development and growth of the in-process CLDPs. IDT member participation: IDT members continued to be very involved in the placement activities of the individuals. Team members thoughtfully evaluated the homes and day programs being explored by the individual. To accomplish this, there were many visits to providers, overnight trials, and IDT meetings to review and discuss. At least one IDT member visited the proposed home and day sites. For example, for Individual #41, the IDT was highly involved in the decision of the home. The first home visited by the individual appeared to be a good option, but upon further examination, potential conflict problems with a housemate was identified. Fortunately, the provider had another home with an opening and that home turned out to be an even better match. Similarly, for Individual #353 there was very good IDT involvement, including looking at a number of different providers. Her CLDP noted she, her IDT, and her LAR were very excited and optimistic about her upcoming move. Unfortunately, given the many problems in placements that occurred for many of the individuals, the APC and transition specialists might take a more active role in ensuring that IDTs are planning for all of the individual's needs, thinking ahead to possible problems that might occur and behavior problems that might re-surface even if they hadn't occurred for many years at the facility. CLDP meeting prior to move: A CLDP meeting was not held during the week of the onsite review. Therefore, one could not be observed. The monitoring team would very much like to observe a CLDP meeting during the next onsite review. Post post-move monitoring IDT meetings: IDT meetings continued to occur after every post move monitoring visit, even if there were no problems. The post move monitor reported that she had been unable to attend any due to travel. The APC should ensure that she can participate, even if by phone for example, for those cases where her participation would be very important to the IDT. Please also see T2a.	

	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	A sample of CLDPs developed and completed since the last onsite review was reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the LA and community provider. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. The three bulleted items in the previous report that indicated additional work that needed to be done still applied (i.e., identifying all of the provider staff who need to be trained, specifying the method of training, and indicating how competency would be determined). o For example, the administrator at Individual #353's community provider found herself having to respond to the occurrence of a serious behavior occurrence during the first week of placement. She was not prepared and did not know how to handle the situation. • In addition to training, the CLDP should ensure that all activities that should be implemented are implemented, that is, supports for implementation after inservice training should be included in the list of required supports (see T1e). • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. This was particularly important at SGSSLC due to the many challenging behavioral and clinical histories of most of the individuals. o Individuals were noted to need to have a psychiatrist in the community, but the CLDP either did not indicate how that psychiatrist would have any contact from the facility psychiatrists who, in many cases, had treated the individual for a long time (e.g., Individual #12, Individual #41). This was further complicated by there not being a psychiatry discharge assessment for any of the individuals (see T1d). o Similarly, the CLDP did not describe how or if community counselors would be available (e.g., Individual #12) and if so how they might learn from the successes of the SGSSLC counselor (e.g., Individual #353). • The CLDP contained a somewhat standardized list of items and actions to occur on the day of the move. The content of this list was appropriate. The assigned staff person was now included, which was good to see. The completion of these activities also needs to be documented. DADS central office continued to conduct reviews of CLDPs at SGSSLC. The monitoring team reviewed the five that were submitted by the facility. Overall, the format allowed for DADS to provide comments on the CLDP and SGSSLC responded to most of these comments. Many of the points brought up by the DADS reviewer were similar to what the monitoring team found, especially regarding the list of ENE supports. DADS might	Noncompliance

		consider some sort of metric to determine if the facility is, or is not, making progress in improving the ENE support list in the CLDPs.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities and the timelines for these actions. This included ENE supports and other pre- and post-move activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual and LAR review. Individuals and their LARs were very involved in the process.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. Therefore, the CLDP document referenced these updated/summarized assessments, rather than full assessments. The updated assessments were sometimes inserted in full into the CLDP and sometimes attached to the CLDP. Sometimes the bulk of the text from the professional assessment was cut and pasted into the CLDP, though not always. The facility should make a decision to either insert all text from all assessments in this section of the CLDP, or to insert none at all. Surprisingly, there were no psychiatry discharge assessments done for any of the individuals. This should occur for those individuals who received psychiatry services at SGSSLC. The monitoring team's review of the CLDPs indicated that the sets of assessments were all completed within 45 days prior to the individual leaving the facility. Changes in the way the IDT's discussions, deliberations, and recommendations were written into the CLDP were done, to a large extent, as recommended in the previous report. For example, in Individual #12's CLDP, the sections included recommendations from the assessment, deliberations and discussion during the CLDP meeting, and the numbering of the assessment recommendations and the deliberations, thereby, making it easy for the reader to follow. Unfortunately, however, across the CLDPs, changes to improve the quality of the assessments were not done as recommended in the previous report. Primarily, the APC and transition specialists were not ensuring that the discipline recommendations were correct and thorough and designed for the new environments. The APC reported that he	Substantial Compliance

		received a new shell for the assessments. The monitoring team believes that, although this will be helpful, it will take more than a new shell for the assessors to successfully provide recommendations truly individualized for the new home and day settings. SGSSLC received substantial compliance at the time of the last review. The monitoring team has kept this rating, but the above improvements must be made if substantial compliance is to be maintained.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	SGSSLC continued to make incremental progress in this provision item since the last onsite review. The monitoring team's review of a sample of CLDP's, however, indicated that more work continue to be needed in order for substantial compliance to be obtained in this provision item. Some activities reported by the APC were: • The APC reported that training was being provided for IDTs, but no evidence was provided to the monitoring team. • The APC directed the training specialists to use a four-part one-page chart to help them to identify ENE supports. The monitoring team reviewed the two submitted by the APC. Although this tool may be helpful, the monitoring team believes it will be insufficient in assisting the training specialists and the IDTs to properly identify all relevant ENE supports. Therefore, the recommendation from the last report is repeated below. Developing this type of self-assessment is not a requirement for substantial compliance, but may help the facility more readily achieve substantial compliance with T1e. o The monitoring team suggests the APC (or transition specialist or PMM) do an ENE support self-assessment <u>prior</u> to finalization of the list of ENE supports. Improvements in the way the discharge assessments are done also help improve the list of ENE supports (T1d). ▪ Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ All safety, medical, and supervision needs were addressed. ▪ What was important to the individual was captured in the list of ENE supports. ▪ The list of supports thoroughly addressed the individual's need/desire for employment. Many individuals are excited to move to the community and do not fully understand that it may take months, if not longer, to find a job. ▪ Positive reinforcement, incentives, and/or other motivating components to an individual's success procedures were included in the list of ENE supports. ▪ There were ENE supports for the provider's <u>implementation</u> of supports. That is, the important components of the BSP, PNMP,	Noncompliance

		dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. ▪ Topics included in training had a corresponding ENE support for implementation. ▪ Any important support identified in the assessments or during the CLDP meetings that was not included in the list of ENE supports should have a rationale. ▪ Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence). • The transition specialists were more often requiring the community providers to create and use simple checklists to document occurrence and implementation of some of the daily activity types of ENE supports. • For Individual #12, the CLDP described an individual and creative component of his transition planning, that is, the individual agreed to start to follow the community provider's morning wake up time and daily smoking schedule during the month prior to his move. There were a number of areas, however, in which improvements were still needed. Rather than providing comments on specific individuals, as has been in done in the previous monitoring reports, below are comments on some general topics related to ENE supports in the SGSSLC CLDPs. <u>Histories of behavioral and/or psychiatric problems</u>: The facility needs to be more thoughtful about individuals with histories of serious behavioral and psychiatric problems. The transition specialists should not be hesitant to include more ENE supports regarding supporting the individual to be as successful as possible. Given the many recent failed placements at SGSSLC, this should be strongly considered. • Although Individual #12 was described as doing very well, there were still some issues in the way he participated or did not participate in activities at the facility. His history included severe schizophrenic episodes, use of weapons, stealing, jail, and elopement. He had been psychiatrically hospitalized five times and had failed community placements, as recent as three years ago. His ENE supports did not address all of the ways he should be supported. • Individual #41 had a history of arson, substance abuse, elopement, and prostitution. She also had been in jail. This history was addressed in her CLDP in two ways, both of which seemed insufficient to the monitoring team. One was a statement that a risk assessment found her to be low risk of inflicting harm on others. The other was a statement from the community provider saying that they didn't have any problems during the trial visit and there would be no	

		restrictions in place for her. • Individual #353 was recently placed at the time of the onsite review, but was having multiple problems that were likely to result in re-admission to SGSSLC. Two items in her CLDP were noted by the monitoring team that pointed to a possible lack of attention to her history. One was her becoming extremely agitated when the day of her move was a few days later than she wanted. The second was a note by the medical department about a serious problem in her often refusing her medications. • Individual #248's community placement recently failed due, in large part, to severe depression. Her history of depression was clearly noted in her CLDP, but there were no ENE supports related to this problem other than ensuring that she saw a psychiatrist. Moreover, the IDT determined to not require implementation of a PBSP in the community because she wasn't engaging in any problem behavior or showing any signs of depression. Unfortunately, there may have been components of her PBSP that contributed to reducing the likelihood of depression that were also discontinued. • Access to cigarettes was a problem for Individual #119. It continued to be an issue that resulted in behavior problems and eventually changing homes at his community provider. <u>Rewards and other aspects of PBSPs</u>: PBSPs often contain lots of procedures that reduce the likelihood of the behavior problem occurring, such as reward systems, successful styles of interaction, ways to de-escalate agitated behavior, structured activity schedules, and so forth. There should be ENE supports that call for implementation of these aspects of PBSPs and there should be documentation to evidence that they were provided. This was not the case at SGSSLC. • The recommendation from psychology to encourage Individual #12 to participate in self-help, community, and social activities was dropped by the IDT and not included as an ENE support (or set of supports) because the team felt that "encourage" could not be measured. It was good to see that the team was thinking thoughtfully about describing evidence, what to measure, and so forth, but that's no reason to drop an important support. The challenge is to define it in a way that is measurable, observable, and recordable. A brief discussion of what the psychologist meant by encourage would likely have led to a good definition of encourage. • Individual #353's ENE supports made no mention of implementing token and activity reinforcers, and the teaching of alternative behaviors, both of which were noted to have played an important role in her success at SGSSLC. • Individual #41's PBSP included components, such as counseling, redirection, replacement behaviors, and token reinforcers. Implementation of these were not included in her ENE supports.	

		• Individual #313's PBSP noted the successful use of token reinforcers at SGSSLC. This were not included in her ENE supports or implemented by her provider. After many problem behaviors occurred after her transition, the provider (as noted in the post move monitoring report) was going to try to implement a token system. <u>Health</u>: Many health-related supports are detailed in the SGSSLC PNMP, dining plan, HMPs, etc. Implementation of the components of these plans is often important to detail in the list of ENE supports. • Individual #64 had an ENE support for implementation of his PNMP. The evidence to demonstrate implementation was noted to be a checklist. The monitoring team was not given this checklist, nor was it included with the CLDP. If it contained all of the daily actions that the community provider should take, then it very well might be a good way to have addressed documentation of daily implementation. It would be important to know that it contained all of the important implementation components to address GERD, dining safety, ground food, and constipation. • For Individual #41, there was nothing in her ENE supports about activities to improve her diet and health, other than to monitor her weight. • Some, but not all, individuals had an assessment topic for risk (e.g., Individual #353). This seemed like a good idea for all individuals. <u>Employment</u>: Work and employment are critically important to the success of many individuals. Most, however, do not have a good understanding of the limitations and hurdles that will need to be overcome in order to obtain community employment. Moreover, they often do not understand the amount of time that may be required to do so. Individuals often are excited to move to the community and will readily say they are OK with going to a day habilitation program or a workshop until other employment can be found, but then have difficulty when employment turns out to not be available for weeks or months. • The IDT and provider were able to maintain Individual #41's community employment after she moved. This was great to see. • On the other hand, the IDT deleted a set of employment-related ENE supports (i.e., DARS referral, vocational assessment, job coach) because Individual #12 said he would be OK to work at provider's workshop and not get a community integrated job. • There were repeated problems that competed with obtaining a job and sometimes with moving to the community, such as not having a state ID card which cannot be obtained without a birth certificate, social security card, and other documentation, which could not be obtained from the facility because the	

		facility did not have it (e.g., Individual #12) or not being able to obtain community Medicaid and an ID (e.g., Individual #353). It would seem that the APC and transition specialists would be experts in knowing what was required. <u>Skills and activities</u>: • Individual #41 was enrolled in the SGSSLC community preparation class after she was referred. Also, three SAPs were carried forward as ENE supports. This was good to see. • Individual #12's ISP, which occurred two months after his referral, included some SAPs to help him prepare for his upcoming move. These included to address his hygiene needs independently, brush his teeth, abide his diet, and participate in family style dining. This was what should occur for all individuals after being referred. • There was, however, nothing in Individual #64's ENE supports about his preference to participate in daily home chores. It was even an action plan in his August 2012 ISP. • There were no ENE supports for activities that appeared to be important to Individual #353, such as learning Spanish, improving her reading and writing, having cell phone minutes available, doing home chores with staff, and cooking. <u>Implementation by provider</u>: Implementation of every important <u>aspect</u> of SGSSLC plans (e.g., PBSP, PNMP, dining plans) needs to be included in the list of ENE supports (i.e., not only a general statement that the PBSP and PNMP will be implemented). <u>Specification of Evidence</u>: There was some progress in describing the evidence that the post move monitor would need to see to show that the ENE support was being provided. For future reviews, the monitoring team would find it helpful to see what some of these look like. • For example, something called an NE Checklist was described for Individual #353's supports. This was likely an example of good progress, but the monitoring team did not have a copy of it. • On the other hand, something called a Progress Narrative was listed for some of Individual #12's ENE supports and a Data Sheet for some of Individual #41's. The monitoring team could not determine what was included on these. • The evidence for implementation of some PBSPs was that a copy of the PBSP was in the home and staff had signed that they were trained. This was insufficient as noted above.	

		This provision item also requires that: • Essential supports that are identified are in place on the day of the move. A pre-move site review was conducted for all individuals. Each review indicated that each essential support was in place. • Each of the nonessential supports needs to have an implementation date. Each nonessential support in the CLDP did have an implementation date.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	The APC and his department continued with the same three statewide self-monitoring tools as described (and criticized) in previous monitoring reports. Although it was good to see that some self-monitoring was occurring, problems in the validity of the tools, their reliability, and the manner in which they were presented to the monitoring team (various pages in the section T presentation book) made it difficult to determine exactly what it was that was done towards meeting this provision item. DADS state office was well aware of problems with the statewide self-monitoring tools and, as a result, was developing a new tool that would be designed to encompass the entire process from referral through post move monitoring. This was good to hear and was urgently needed. Further, it would be in line with meeting the requirement of T1f (i.e., a quality assurance process to ensure that the CLDPs are developed and implemented). State office and the APC should consider creating a tool to also monitor the quality of all of the provision items of section T, too. The quality assurance process for section T needs to be planned out and included in the facility-specific policy for most integrated setting practices. The monitoring team recommends that this be a separate facility-specific policy. Further, the monitoring team suggests that a quality assurance process be more than just the (new) self-monitoring tool and include: • The statewide self-monitoring tool • Graphs of the outcomes of these tools • Graphs of the other outcomes noted throughout this report, especially in T1a • Section T benchmark meeting summaries and monthly data submissions • The provision T section of the QA report • Presentations to QI Council • Corrective actions and/or corrective action plans Regarding the section T presentation in the QA report: the line graph of community placement related information had too many lines, especially resulting in the squashing of five lines at the bottom of the graph, thereby, making these lines of little practical value to the reader.	Noncompliance

T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	The same state report that was discussed in the previous monitoring report was again submitted. It was an annual report. The new report was due in the near future. The APC did not submit a quarterly report as he had done last time (it was not required by the Settlement Agreement). That being said, the APC continued to maintain the spreadsheet described in T1b1 regarding his review of obstacles at the individual level. He also updated and maintained the spreadsheet that listed the obstacles for each individual. The data from this spreadsheet were to be used in the next annual report.	Noncompliance
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 6/1/12 through 12/1/12. Although not yet included, the facility and state's intention was to include, in future Community Placement Reports, a list of those individuals who would be referred by the IDT except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral.	Substantial Compliance

	previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any	SGSSLC maintained substantial compliance with this provision item. <u>Timeliness of Visits</u>: Since the last review, 43 post move monitorings for 20 individuals were completed. This compared to 34 post move monitorings for 15 individuals at the time of the last review. This was 100% of the post move monitoring that was required to be completed. All 43 (100%) occurred within the required timelines and both the residential and day programs were visited. This was particularly impressive given the increase in post move monitoring activity by about 30% and given that all post move monitoring activity was conducted by the one PMM, Denise Copeland. The monitoring team reviewed completed documentation for all 43 (100%) post move monitorings.	Substantial Compliance

	support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Content of Review Tool: All 43 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. Below are comments regarding the content of this set of 43 post move monitorings. • The post move monitoring report forms were completed correctly and thoroughly. Good information was included. • Overall, the reports indicated that the PMM was conducting post move monitoring as per the requirements and intentions of this provision item. • The PMM continued to complete the checklists in a cumulative format. This made it very easy for the reader to follow the individual through his or her first 90 days in the community. • Good detail was included in the evidence boxes for each of the ENE supports. This made it easy for the reader to understand more detail rather than merely checking the yes/no box. • LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in every review. • The individual's psychiatric diagnoses, psychiatric medications, and medical conditions were now inserted right into the post move monitoring form. This helps the PMM to be more efficient when conducting interviews. • There were few typographical errors found. This was a nice improvement, too. • Only some of the reports included summary subjective comments regarding the PMM's overall opinion of the placement and the individual's happiness there. This was very helpful when it occurred and was appreciated by the reader. These should be included in all reports. • It would be helpful to the reader if the people who were interviewed and/or observed were listed on the first page of the report. Of the 20 individuals who received post move monitoring that was reviewed by the monitoring team, 12 (60%) were maintaining successfully or fairly successfully in the community. Of these 12, however, 5 had serious events occur during their first 90 days in the community. So, even though they were doing OK at the time of their most recent post move monitoring, it was not without problems and incidents that were far beyond what one might expect as a normal part of a transition and severe enough that they might have resulted in a return to the facility. Of these 12, 1 was arrested and jailed, 3 were hospitalized in a psychiatric hospital, 2 were prescribed psychotropic medications they hadn't been receiving while at SGSSLC, and 1 had to change homes (some individuals had more than one of these untoward outcomes). Thus, of the 20, only 7 (35%) had transitions that went as the IDT, for the most part, expected.	

		Of the other 8 individuals (40%) who received post move monitoring, 4 had returned readmitted to the facility, 2 were likely to soon return to the facility, and the other two remained unstable in their placement. As discussed with the APC, a review needs to be done of the individuals whose placements failed and those whose placements had the kinds of problems noted above. One would expect that some changes in the way placements and transitions are planned at SGSSLC would result. This is also noted above in T1a. <u>Use of Best Efforts to Ensure Supports Are Implemented:</u> IDTs, the APC, the transition specialists, and the PMM put a lot of effort into these placements. The PMM appeared to do a good job of following up when there were problems. For example, she did extra follow-up between the 45- and 90-day timelines for Individual #248 when she was notified about problems. The monitoring team, however, believes that: • More should be done when supports are not implemented, not implemented correctly, and/or if there are problems in the placement. It seemed that it was impossible for the PMM to regularly attend the ISPA meetings that followed each post move monitoring due to her extensive travel schedule. As a result, perhaps, the ISPA documentation did not reflect much action taken by the IDT even when notified of problems (such as those listed above regarding the many individuals who had problems after placement). The APC, PMM, and transition specialists should work on a solution to this. o For example, at Individual #184's 45-day ISPA it was noted that he'd made an obscene phone call, was on a new psychotropic medication, and there were reports of him being highly agitated. This was not addressed by the APC, transition specialist, or IDT. • At the end of the 90-day review period for Individual #330, there was still no resolution to her having a psychiatrist and having a day program. Post move monitoring should have continued past the 90-days until these issues were resolved. IDT meetings were held following the post move monitoring visits. This was good to see. Documentation of these meetings was submitted for 43 of the 43 (100%) post move monitorings reviewed by the monitoring team. As noted above, the ISPA meetings did not appear to accomplish what they were designed for, that is, thorough review of any problems that might be occurring post-placement. The monitoring team continued the rating of substantial compliance for this provision item by taking into account the thoroughness of post move monitoring done by the PMM and the continued improvements seen in her post move monitoring. The topics noted in	

		this section of the report, T2a, should be addressed if substantial compliance is to be maintained at the time of the next onsite review.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	Unfortunately, a post move monitoring visit that the monitoring team could attend could not be scheduled during the week of the onsite review for the monitoring team to attend. For the next review, the monitoring team is available during the weeks prior to the review to schedule with the facility to make this more likely to occur.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the	Two individual was discharged under this T4 provision. Both were discharged because they no longer qualified for services. The discharge documents were done properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team.	Substantial Compliance

	provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

1. Identify those individuals who would have been referred except for the preference choice of the LAR; this list should include not only those who themselves requested referral, but those individuals who themselves cannot express a preference, but whose IDTs would otherwise have referred. Add this list to the Community Placement Report (T1a, T1h).

2. Do a detailed review (i.e., root cause analysis) of each rescinded referral, each failed placement/re-admission to the facility, and any other untoward post move serious incidents to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a, T2a).

3. Expand the current set of graphs, and include them in the facility's QA program (T1a, T1f).

4. Consider participating in the creation of the transition home (T1a).

5. Implement procedures so that professionals' opinions and determinations regarding community placement are in their annual assessments, in the ISP meeting discussion, and in the ISP document (T1a, T1b3).

6. Check with state office regarding how to rate individual preference for individuals who themselves cannot clearly indicate a preference (T1a).

7. The APC should regularly present to senior management regarding the status of all referrals (T1a).

8. Facility-specific policies will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated (T1b).

9. Upon referral, the APC should seek out the IDT and others as noted in T1b1 to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

10. Ensure that the APC individual obstacle spreadsheet contents are valid (T1b1).

11. Attend to the detail provided in T1b2. The nine bulleted lists might be used in the facility's self-assessment process (T1b2).

12. Ensure that there are thorough living options discussions and living option determinations. The living option determinations should include a clearly worded rationale for the decision made by the IDT as a whole. See the four bulleted items in T1b3 (T1b3).

13. Ensure that CLDPs are developed and implemented in a timely and regular basis, that there are no unexplained gaps in time of transition planning activity, and that in-process CLDPs contain relevant information (T1c).

14. Ensure PMM participation in ISPAs for post move monitoring if there are unresolved issues, failure to provide ENE supports, or any active problems (T1c, T2a).

15. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency) (T1c1).

16. Collaborate with community and provider clinicians, especially but not limited to the PBSPs and psychiatry (T1c1).

17. Document the completion of the day of move activities (T1c1).

18. Determine if the state office CLDP reviews are resulting in improvements in the CLDPs (T1c1).

19. Ensure assessments are for the upcoming move to new home and day/employment settings and that they are thorough and complete (T1d).

20. Ensure psychiatry discharge assessments are completed for those individuals for whom it would be needed (T1d).

21. Make sure a wide range of ENE supports are identified, and that no important aspects of the individual's life fail to have a corresponding ENE (T1e).

22. Clearly describe the ways the PMM should evidence the occurrence of the <u>implementation</u> of supports by the provider (T1e).

23. The monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted in T1e (T1e).

24. Develop an organized QA program for section T (T1f).

25. Develop new self-monitoring tools (T1f).

26. Ensure follow-up on all supports for which follow-up is needed (T2a).

27. Include a summarizing subjective statement in each post move monitoring report about the placement and the individual's lifestyle there (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SGSSLC Policy: Rights of Individuals with Developmental Disabilities dated 10/12/01 o SGSSLC Informed Consent Tool o SGSSLC Functional Assessment Tool o ISPs and Rights Assessments for : • Individual #60, Individual #215, Individual #223, Individual #379, Individual #207, Individual #132, Individual #50, Individual #38, Individual #99, Individual #174, and Individual #130. o SGSSLC Section U Presentation Book o A Sample of HRC Minutes o SGSSLC Prioritized Guardianship/Advocate List o A list of individuals for whom guardianship had been obtained in the past six months. o Documentation of activities the facility had taken to obtain LARs or advocates for individuals Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QDDPs in homes and day programs; o Roy Smith, Human Rights Officer o Zula White, Human Rights Office Administrative Assistant o Dana Robertson, Section C Provision Coordinator o Michael Davila, QDDP Coordinator o Vanessa Barrientez, QDDP Educator o Roy Smith, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 12/2/12 and 12/3/12 o Unit 1 Morning Meeting o Administrative IDT Meeting o Annual IDT Meeting for Individual #48 and Individual #127 o Human Rights Committee Restraint Review Meeting 12/3/12 o QA/QI Committee Meeting
	Facility Self-Assessment: SGSSLC submitted its self-assessment. The self-assessment was updated on 11/19/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct

	the self-assessment, the results of these self-assessment activities, and a self-rating for each item. The facility self-assessment described criteria used to evaluate compliance for each item and details on specific findings. For example, for item U1, the self-assessment activities engaged in by the facility included a review the state guardianship policy, review of section U monitoring tool data, and a review of the ISP monitoring tool data to ensure discussion regarding guardianship and the individual's ability to give informed consent was documented. The facility's self-assessment activities were similar to those completed by the monitoring team to assess compliance. The self-assessment included specific data gathered and summarized progress made. The human rights officer was aware of where the facility had made progress and what areas continued to need more work. He was providing needed guidance to IDTs. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance ratings for U1 and U2, though notable progress had been made.
	Summary of Monitor's Assessment: The facility had recently revised the assessment process for determining the need for guardianship. IDTs were in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. This assessment process will need to be fully implemented for compliance with U1. Then U2 will be the next step, which is procuring guardians for individuals assessed as high priority. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The facility was still in the initial stages of developing a priority list of individuals needing an LAR based on an adequate assessment process. IDTs continue to need training to determine each individual's functional capacity to render informed decisions. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need. The human rights officer, assistant independent ombudsman, and human rights office administrative assistant worked very closely with individuals and their IDTs to ensure protection of rights at the facility. They were actively involved with every department at the facility and served as an invaluable resource to IDTs.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	A prioritized list of individual lacking both functional capacity to render a decision and a LAR to render such a decision was still in place, though the facility still lacked a formalized assessment process that included adequate IDT discussion. The facility maintained a prioritized list of individuals in need of an LAR. The current list identified 32 individuals as Priority I or high need for an LAR, 26 individuals as Priority II, and 17 individuals as Priority III. This list was based on the need for restrictive practices, the individual's ability to advocate for himself/herself, the presence of an active advocate, and the individual's risk level. A sample of ISPs and relevant assessments was reviewed to determine the adequacy of IDT discussion regarding individuals' ability to express their own wishes or make determinations regarding their health or welfare. Most ISPs in the sample documented a brief discussion on guardianship. None included an adequate discussion of the individual's ability to express his or her own wishes or make determinations regarding his or her own health or welfare. For example, • The ISPs for Individual #379 simply stated that he was an adult with no legal guardian. There were several comments throughout the ISP referencing his lack of understanding of money, community living options, and medications. The ISP did not document a discussion regarding the need for guardianship. • Individual #130's ISP documented a much better discussion around the need for guardianship. The team discussed her inability to make decisions in a number of key areas, such as medical, program options, and living options. The team determined that she was in need of guardianship and made a referral for guardianship. It was not clear whether or not she could make minor day to day decisions or how she expressed her preferences. The annual IDT meetings were observed for Individual #48 and Individual #127. • Individual #48 had a guardian. Her guardian was not present for the meeting. The IDT did a nice job of including the individual in the discussion and planning for the upcoming year. The team encouraged her to voice her opinions and offered further explanation to her when she appeared to need more information regarding her choices. Her rights assessment was completed and reviewed with her. • The IDT for Individual #127 agreed that he could not give informed consent in a number of important areas. The team determined that he was a Priority I for guardianship and agreed to refer him to the human rights officer to pursue	Noncompliance

#	Provision	Assessment of Status	Compliance
		guardianship. IDTs were holding a more thorough discussion regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship was based on an assessment process and this discussion. Though much progress had been made, the facility was not yet in compliance with this provision.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members and community groups. Two individuals had been assigned new guardians since the last visit by the monitoring team. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human rights officer employed by the facility. The facility continued to offer self-advocacy opportunities for individuals at the facility, including a very active self-advocacy group. As noted in section E, the group continued to grow and meetings provided a great opportunity for individuals to learn more about decision making and self-advocacy. In addition, each home conducted a weekly home meeting led by the home manager. The purpose was to provide the individuals who lived in each home the opportunity to contribute to discussion regarding house rules, choices of activities, and discuss any problems occurring in the home. This was another great opportunity for individuals to practice self-advocacy and decision making skills. There was variability in home manager facilitation skills in these home meetings and additional training and support to home managers would be helpful to them, as noted in E1 above. There was a Human Rights Committee (HRC) at the facility that met to review all emergency restraints or restrictions, all behavior support plans and safety plans, and any other restriction of rights for individuals at SGSSLC. The Human Rights Officer continued to facilitate good discussion at the meetings. The committee was thoughtful in their approval process and required that when a restriction was necessary, the IDT must have a clear rationale, along with a plan to eliminate the restriction when reasonable. The facility continued to make progress in this area, however, compliance with U2 will be contingent on a larger number of individuals going through the newly developed assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	Noncompliance

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).

2. Maintain a prioritized list of individuals that need a guardian based on IDT recommendations (U1).

3. Explore new ways to support the rights of individuals while working through the guardianship process. Some other options outside of guardianship that the facility should explore are active advocates for individuals and health care proxy/medical power of attorney for individuals (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o SGSSLC recordkeeping-related policies: • Active Record Guidelines, updated 9/27/12 o SGSSLC organizational chart, undated o SGSSLC policy lists, 5/25/12 o List of typical meetings that occurred at SGSSLC, (not provided) o SGSSLC Self-Assessment, 11/19/12 o SGSSLC Action Plans, 11/16/12 o SGSSLC Provision Action Information, most recent entries 11/16/12 o SGSSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 12/4/12 o Recordkeeping department QA benchmark meeting summaries, August 2012 to November 2012 o Recordkeeping QA report section, once, September 2012 o Recordkeeping department presentations to QI Council, once, 9/26/12 o List of all staff responsible for management of unified records o Description of changes in the recordkeeping processes since the last review, two pages o Documentation of new employee orientation, June 2012 to November 2012 o Tables of contents for the active record, individual notebook, and master record 5/23/12 o List of other binders or books used by staff to record data o Description of the SGSSLC shared drive and All About Me folder, one page o List of medical consultations for the 9 unified records audited in November 2012 o Various training and home secretary meeting minutes and notes, 8/23/12-11/29/12 o A 7-page spreadsheet that listed state and facility-specific policies and also showed various information regarding training (e.g., who, how, data/numbers), undated, probably November 2012 o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Home secretary monthly audit information, June 2012 to November 2012 o QA department benchmark meeting data and notes, August 2012 to November 2012 o Description of the unified record audit process, one page o Blank tools used by the URC, November 2012 o List of individuals whose unified record was audited by the URC, August 2012 to November 2012 o Completed unified record audit tools (and/or summaries), June 2012 to November 2012; by November 2012, consisted of: • Active record and individual notebook (new single tool) • Master record • V4 questionnaire

	• All About Me shared drive file o Audit errors and recommendations for correction, for each individual o Emails showing notification of responsible persons, about 100 pages for August 2012 audits o Various graphs that summarized some aspects of recordkeeping activities and findings, August 2012 to November 2012 o Description of how SGSSLC addresses section V4, two pages o Various forms, tools, tables, and graphs regarding V4 activities, August 2012 to November 2012 o Active records and/or individual notebooks of: • Individual #175, Individual #99, Individual #35, Individual #371, Individual #16, Individual #215, Individual #370, Individual #381, Individual #48 o Master records of: • Individual #354, Individual #349 <u>Interviews and Meetings Held</u>: o Cary Lovelace, Unified Records Coordinator o Juanita Brake, Director of Client Records Department o Leticia Williams, QA staff member, and Marsha Jones, Settlement Agreement Clerk o Angela Kissko, Quality Assurance Director o Various DSP and management staff <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area in administration building
	Facility Self-Assessment SGSSLC continued to use the self-assessment format it developed for the last review. The new Unified Records Coordinator (URC), however, further developed the self-assessment from what was presented last time by including additional activities and outcomes. In that regard, she made progress in that she was trying to look at actual activities and outcomes for each provision item. This time, the improvement included an attempt to look at the types of things looked at by the monitoring team. To that end there were many activities listed in the "activities engaged in" section that were more in line with the monitoring team's report than ever before. For V1, the URC self-assessed by looking at (a) whether all new admissions had a unified record, (b) the results of the implementation of the V3 audits, and (c) the status of the master record reviews. Her results showed that every individual, and all new admissions, had a unified record. Her review/summary of the V3 audits detailed data for last six months, however, her new audit tool was implemented in September 2012, making September 2012 and October 2012 data the most valid and relevant to this monitoring review. The aggregated self-scorings were 66% and 77% for those two months. For the master records, she reported zero and two corrections needed for each of the two months, respectively. Based on her findings, she self-

	rated noncompliance and summarized her rationale as there being continued problems in documentation, inaccuracy of documents completed and filed, and overall compliance of all sections being monitored. This was, for the most part, a good self-assessment and was in agreement with what the monitoring team found. To be more in line with the monitoring team, the URC should report separately on active records, individual notebooks and/or any other binders or logs, master records, the shared computer drive, and the status of overflow filing. She might also self-assess the status of policies, URC conducting of trainings and inservices, and the implementation and outcomes of the home secretary audits. For V2, the QA director (a) reviewed the SGSSLC policy on policies and (b) reviewed whether all state policies that required operationalization by the facility were indeed operationalized by the facility. For future self-assessments, she should self-assess whether every Settlement Agreement provision has a corresponding state policy, and also self-assess the status of trainings on policies (for which the facility was beginning to collect and report data). For V3, the URC reviewed the recommendations/errors/corrections electronic spreadsheet and the corresponding graphs. She also self-assessed whether the required number of audits were conducted, the number of recommendations, and any trending or analysis. These were all good items to include in the self-assessment. She might also self-assess inter-rater agreement and the completion of the set of graphed, trended data described in V3 below. She might also self-assess if analysis of the data was conducted and if any corrective or special actions were taken as a result. For V4, she self-assessed some, but not yet all, of the six activities of V4. Even so, this showed good progress in her self-assessment actions. It may make sense to self-assess each of the six activities, in addition to reporting an overall self-assessment of V4. The facility self-rated itself as being in noncompliance with all four items of provision V. The monitoring team agreed with these self-ratings. That being said, much progress was noted, as detailed in the report below.
	Summary of Monitor's Assessment: SGSSLC continued to make very good progress with all four of the items of provision V. This was due, in large part, to the work of the new unified record coordinator (URC). She was an active participant in the many facility-wide activities related to the Settlement Agreement. She taught new employee orientation; conducted various trainings for home secretaries, clinical discipline department staff, and residential unit staff; and met each month with the home secretaries. A unified record existed for all individuals, including all new admissions. The active records continued to improve. There were fewer blank gaps in the IPNs, observation notes, and physician's orders. There were no non-IPN documents in the IPNs. A list of medical consultations was

	created so that the URC now knew what to look for in the medical consultation section of the active record. RNs were now expected to file a number of medical documents into the active records themselves, rather than wait for the home secretaries to do so. Even so, there continued to be many missing and/or incorrectly filed documents. Many documents were old, outdated, and/or expired. Updates and/or recent regularly scheduled reviews were not in the record. Some documents were not removed from the active record as required (i.e., purged, thinned). Errors in legibility or correctness of handwritten entries and/or signatures and credentials, and/or missing signatures were observed in all of the active records (though this appeared improved somewhat from the previous review). Some data were missing from SAPs. SGSSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks. The individual notebooks tended to be stored away, locked in the home offices. Therefore, the notebooks did not appear to be readily available for use by DSP staff. A number of documents were kept separate from the individual notebook. these logs and sheets should be considered to be part of the individual notebook (even though they're not kept in the individual notebook). SGSSLC maintained the same satisfactory system of managing the master records. The URC recently began including the All About Me shared drive folder in her monthly audits. This was a very good idea. The QA director re-built the facility's list of policies in response to the needs of provision item V2 and recommendations in the previous monitoring report. Included were the first attempts at data collection regarding training on policies. Continued progress was made in the reviews of the unified records. Five or more audits were conducted in each of the past six months. The new URC revised and improved the process beginning in September 2012. For example, she combined the detail required by the table of contents tool with the criteria and variables listed in Appendix D of the Settlement Agreement. The URC completed all of the audit forms by hand and then later entered the information into her electronic spreadsheet. This automatically calculated a variety of compliance scores. There were some graphic summaries of some data, but they needed to be improved. For V4, the facility showed progress by taking first steps to assess, and possibly address, the six activities of this provision item. For example, the URC revised the V4 tool and in it included items directly relevant to some of these six activities (#1, #3, #4, and #5).

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	SGSSLC continued to make very good progress with all four of the items of provision V. This was due, in large part, to the work of the new unified record coordinator (URC), Cary Lovelace. She began her role as URC in August 2012, when the previous URC took a different position at the facility. It took Ms. Lovelace a month or two to thoroughly learn the recordkeeping systems at SGSSLC. Then she updated and further improved a system that had already been making progress towards substantial compliance. The URC, with support from the QA director, and from the home secretaries, took very seriously the comments, suggestions, and recommendations in the previous monitoring report. This contributed to the progress seen in all components of the unified records. A unified record existed for all individuals, including all new admissions. The URC's self-assessment indicated that (since initiation of her new self-monitoring tool in September 2012) progress was being made, though more work was needed. The monitoring team's review of a sample of unified records also indicated that the records continued to improve since the last review, but that further improvement was needed. Details are provided below in the monitoring team's report on the four items of this provision. The URC was an active participant in the many facility-wide activities related to the Settlement Agreement and quality assurance. That is, she participated in and prepared for monthly QAD-SAC-department meetings (benchmark meetings), prepared a quarterly QA report, presented section V quarterly at the QI Council, and completed self-assessments, action plans, and provision action descriptions. She had, however, only been through one round of these activities because she started in her role in August 2012. At the September 2012 QI Council, she reported that a unified record existed for every individual, not all were maintained thoroughly, and that legibility was an issue. The facility director said that everyone at the facility should try to avoid any and all delinquencies (in recordkeeping). The URC taught the new employee one-hour orientation session on recordkeeping practices. She conducted various trainings for home secretaries, clinical discipline department staff, and residential unit staff. She met each month with the home secretaries to review problems, issues, progress, and any changes in recordkeeping practices. Agenda topics and notes were on topics very relevant to recordkeeping. The home secretaries (nine) were supervised by the three facility unit directors. The monitoring team, after talking about this supervisory structure with the unit directors and URC, recommends that the facility consider moving their supervision to the URC. This would allow the home secretaries to receive more direct supervision and accountability for their work. Further, it would alleviate a responsibility of the unit directors. The unit directors and the URC all agreed that this would be a good change.	Noncompliance

#	Provision	Assessment of Status	Compliance
		State policy remained the same since the last review. The one facility-specific policy, Active Record Guidelines, was updated on 9/27/12 regarding RNs filing in the active record and records requests related to the conduct of annual physicals. The updates were highlighted in the policy copy given to the monitoring team. This was appreciated. In the URC's action plans, she planned to further update the facility policy regarding IPNs, the dating of documents, and ensuring that the table of contents was correct for the needs and activities of each clinical department. <u>Active records</u> The active records continued to improve. The monitoring team reviewed active records in each of the three units at the facility. Improvements were noted in the following areas, some of which were in response to recommendations in the previous report. • A new table of contents and guidelines were created in May 2012. There were only some minor changes made, primarily in the notes and directions to the home secretaries. Small incremental changes are one indication of ongoing progress. • Home secretaries were doing an audit each month of the active record of one of the other home secretaries. It was an abbreviated audit (compared to the URC's audits). For example, it required primarily checking for the presence and placement of documents in the active record. Each of the two unit secretaries (who worked for the unit directors) conducted an inter-observer agreement check. Results for the past three months (September through November 2012), however, showed variable interobserver agreement (65% to 85%), thereby questioning, somewhat, the reliability of the home secretaries auditing results. The monitoring team recommends that the URC examine the causes for any lack of agreement, and perhaps conducting an occasional inter-observer agreement check herself. • There were few blank gaps in the IPNs, observation notes, and physician's orders. • There were no non-IPN documents in the IPNs. This was noted as a recommendation in the previous report. • Work was done, though not yet completed, regarding making changes in the OTPT sections of the active record to ensure proper forms, table of contents, and guidelines were in place. The URC was meeting with the habilitation director to this end. The URC shared the edits and mark up done by the habilitation director on the original table of contents that indicated the changes to be made. This was also noted as a recommendation in the previous report. The	

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		monitoring team recommends that state office be contacted for approval if there are any potential removals or deletions of items from the state's original table of contents. o Based upon her impending success in doing this with the habilitation director, the URC reported she planned to meet with each clinical discipline director to review (and perhaps improve) the active record contents for each discipline. • The therapy sub-tab under the psychology section remained, with good result, according to the psychology department staff. • A list of medical consultations was created so that the URC now knew what to look for in the medical consultation section of the active record. This was another recommendation from the previous report to which the URC and the facility were responsive. o The monitoring team recommends that the home secretary audits also include a check of the presence of medical consultations. • RNs were now expected to file a number of medical documents into the active records themselves, rather than wait for the home secretaries to do so. This change came about after the URC and home secretaries found delays in the filing of medical information labs, consultations, physician's orders etc. They called a meeting with the ADOP, interim medical director, medical secretary, CNE, and unit directors and came up with this plan. After two weeks of implementation, the URC assessed implementation, a few changes were made, and it now seemed to be working well. • The medical volumes of the active record were moved to the medical rooms in the homes for easier access by those staff medical, nursing, and clinical staff who used them most often. Even so, there continued to be a need for further improvement in the active records as found in the facility's own audits (V3 and home secretaries) and its own self-assessment, in the monitoring team's review of a sample of unified records at SGSSLC, and during the monitoring team's detailed review of Individual #175 and Individual #99's active records with the URC. • There were many missing and/or incorrectly filed documents. The documents missing varied across the active records sampled. They included missing social history (Individual #175), psychology-related documents (i.e., functional assessment, Reiss screen) (Individual #175), speech and audiology documents (Individual #99), functional skills assessment (Individual #371), and ISP reviews (Individual #215). • Many documents were old, outdated, and/or expired. Updates and/or recent regularly scheduled reviews were not in the record. Current documents that	

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		were missing included rights and consents (Individual #175, Individual #371), psychiatry reviews, MOSES/DISCUS, and QDRRs (Individual #99), functional assessments (Individual #371, Individual #215), PBSPs (Individual #371, Individual #175), and diet/nutritional assessments (Individual #99). • Some documents were not removed from the active record as required (i.e., purged, thinned). • Errors in legibility or correctness of handwritten entries and/or signatures and credentials, and/or missing signatures were observed in all of the active records, though this appeared improved somewhat from the previous review. o An extensive re-training was done by home managers for all of their DCPs in November 2012. Lots of documentation was provided to the monitoring team (more than 300 signatures in 20 different sessions). This will likely improve legibility. It is also a simple training that should be regularly scheduled from time to time to reduce the likelihood of a decrease in performance. • Some data were missing from SAPs. This was considered to be an error by the URC because staff who implemented SAPs were supposed to make a notation as to why a SAP was not implemented on any day on which it was supposed to be implemented (i.e., similar to what is required on MARs). • A variety of nursing related documentation problems were noted in the IPNs and in other records. Please see details in section M1 of this report. Most of the problems identified were not due to failures by the URC and/or the home secretaries. In fact, most of the errors were due to documents not being properly submitted to the recordkeeping staff for them to file into the active record. The URC's self-assessment and monthly audits, and the audits done by the home secretaries indicated the same types of issues that were found by the monitoring team. For example, the URC reported in her self-assessment that there continued to be problems in written entry documentation, inaccuracy of documents completed and filed, and overall compliance of all sections being monitored. She reported data on 14 topics/items with scores of 66 and 77% for September 2012 and October 2012. On the other hand, the home secretary audits showed an extremely high rate of performance, 90% to 94%, over the past three months. As noted above, there may be some problems in the reliability of the data, that is, in the accuracy of home secretary recording (i.e., unintentional bias, inflated scores). Note that discussion of the home secretary audits is included here in V1 because they were part of the process used at SGSSLC to create and to maintain good quality active	

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		records. Although it is an audit process, it did not meet the requirements of V3 because the home secretary audits were limited to one aspect (presence and filing) of one component of the unified record (active records). Even so, the monitoring team positively acknowledges this system and the efforts of the URC, home secretaries, and unit secretaries. <u>Individual notebooks</u> SGSSLC continued to use individual notebooks. The URC reported that staff were recording data on a daily basis. Staff appeared comfortable and knowledgeable about the individual notebooks. For example, Dustin Guava, DSPI staff member, showed the monitoring team the individual notebook and described how he used the individual notebook after dinner for recording SAP data. He also showed the Habscan data cards (which are used for recording behavior data and kept in the staff member's pocket throughout the day) and the laminated card that showed the correct Habscan numbers for each individual separately and uniquely. Observation notes appeared appropriate and were moved from the individual notebook into the active record in a timely manner. This was done at the end of the month. The monitoring team noted that individual notebooks tended to be stored away, locked in the home offices. Therefore, the notebooks did not appear to be readily available for use by DSP staff. The monitoring team recommends that the URC and recordkeeping department explore whether the individual notebooks are available to DSP staff when, and as, needed. <u>Other binders/logs</u>: A number of documents were kept separate from the individual notebook. This included aspiration triggers logs and intake/output sheets for all homes, and behavior logs for some homes. This is acceptable, however, these logs and sheets should be considered to be part of the individual notebook (even though they're not kept in the individual notebook). Therefore, they need to be regularly reviewed by the recordkeeping staff and included in any audits of the individual notebooks. <u>Master records</u> SGSSLC maintained the same satisfactory system of managing the master records. Overall, the master records were in good shape. The master records had a lot of documents in them, perhaps more than necessary. The URC appeared to be working closely with the manager of the master records, Juanita Brake. For example, they created a new master record audit tool and table of contents that indicated the minimum documents that needed to be in the master record.	

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		Still to be resolved, however, was what to do when non-optional master record documents could not be located or obtained. The URC proposed that a new practice be to notify the IDT and then document the IDT's response in the master record. Thus, there were the beginnings of a plan to address this need. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department and the quality assurance department reported that there were no items in the shared drive that were not in the unified record as a hard copy. Even so, the shared drive contained a lot of information about the individual and was used regularly by facility staff. As a result, the URC recently began including the All About Me shared drive folder in her monthly audits. This was a very good idea because many staff used the shared drive to review documents. If a document in the shared drive was out of date or missing, the staff member, if he or she did not check the active record itself, might not have the most up to date information. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	This provision was managed by the QA director. She re-built the facility's list of policies in response to the needs of this provision item and recommendations in the previous monitoring report. That is, she created a seven-page spreadsheet that listed every policy at SGSSLC and had seven columns of relevant information, such as the state policy name, number, and date; any corresponding facility policies names, numbers and dates; and five columns related to facility training on these policies. The columns were • Who provides the training • What staff are required to receive the training • How often is training to occur • Number of staff who are supposed to have received training • Number of staff who did receive training. Although not yet completed (i.e., not all of the policies included data on the number of staff to be trained or the number that had been trained), the creation of the spreadsheet and the work done by the QA director to begin to determine the answers to these training-related bullets demonstrated good progress on this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, not all state policies were in place yet, though continued progress was evident. The monitoring team has the following recommendations as the QA director moves forward with provision item. • Add the corresponding Settlement Agreement provision letter to the policy name, number, and date in the State Policy column. • Include an "as of" date on this spreadsheet so that the reader knows that the training data were valid/correct as of a certain date. Because many trainings need to be re-done periodically, the "as of" date will be important to the reader. • For each policy, either in a new column, or within the "Who provides training column," include o what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), o type of documentation necessary to confirm that training occurred and where this documentation is stored and summarized. The facility had a process for reviewing and approving facility policies. It was reported to being in the process of being revised. It was good that the facility had a process for the review and approval of facility policies.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Continued progress was made in the quality and management of the monthly process for the review of unified records, including addressing the recommendations and comments made in the previous monitoring report. This was due to the efforts of the new URCs, the QA director, and the home secretaries. Moreover, staff throughout the facility were responsive when notified by the recordkeeping staff about any errors found in the records and any needed corrections. Five or more unified record audits were conducted for each of the past six months. The new URC revised and improved the process beginning in September 2012. Therefore, although the monitoring team reviewed all six months of audits, comments in this section of the report are limited, appropriately, to the updated auditing system. Many of the URC's revisions were in response to previous comments and recommendations from previous reviews. The monitoring team acknowledges these efforts. The URC's initial major revision was to create a new audit tool. This took effect in September 2012, however, additional changes occurred in each of the subsequent months (and likely will continue between now and the next onsite review).	Noncompliance

#	Provision	Assessment of Status	Compliance
		The new audit tool, 12 pages long, combined the previous table of contents (TOC) tool and the previous statewide section V tool to audit the active record and the individual notebook. This was an excellent idea because there was a need to combine the detail required by the TOC tool with the criteria and variables listed in Appendix D of the Settlement Agreement and included in the statewide tool. Thus, the URC rated, for every item in the TOC for the active record and for the individual notebook, whether it was legible, current, complete, and so forth. This was very good to see. Further, the tool was pre-populated with NA for those items that were always NA. Also included in this tool were items for rating whether the active record and individual notebook accessible, locked when appropriate to do so, and properly thinned and stored. Other changes made by the URC are listed below: • Nine audits were conducted each month (October 2012). The choice of the nine individuals whose unified records were audited each month were chosen in a semi-random, systematic manner so that there was one individual from the caseload of each of the nine home secretaries. Further, because each home secretary's caseload included more than one home, she ensured that homes were sampled from month to month. • The shared drive folder All About Me was included in the active record audit (November 2012). The URC looked to see if what was in this shared folder matched what was in the active record, and if not, how to correct. The URC regularly found 10 to 20 documents that were either missing from the shared folder or the active record, or that were out of date. • A list of medical consultations was obtained from the medical department and used for the active record audit (November 2012). • A high standard was created, such as including any missing SAP data entries as a recommendation for correction. • A new master record audit form/tool was created. It now became part of master record, too (September 2012). • The V4 tool was revised and the results were incorporated into the unified record audit results and percentage scoring (October 2012). The URC should consider modifying the falsification rating as discussed with the monitoring team so that it accurately reflects that absence of falsification of data. Also, when the URC, during her audit, removes a document that should not have been thinned from the record, but wasn't, she conducted and documented re-training of the home secretary. These instances should be included in the count of recommendations, too.	

#	Provision	Assessment of Status	Compliance
		The URC completed all of the audit forms by hand and then later entered the information into her electronic spreadsheet. This automatically calculated a variety of compliance scores. Then she entered every recommendation into another electronic spreadsheet that allowed her to count, track, and follow-up on every recommendation. Emails were sent to appropriate responsible persons and included a due date and what evidence was needed to show that the recommendation was corrected. For recommendations that could not be corrected (e.g., an illegible signature), documentation of re-training of staff sufficed as a correction. This made sense to do it this way. The URC followed recommendations for two months. Supervisors were notified of any that were not completed by that time. Interobserver agreement was collected once per quarter for one of the audits (i.e., 1 out of 27, 3.5%) by the QA department. The most recent one was done in October 2012. The IOA was reported to be 83%, however, most of the QA staff member's scores were lower than the URCs. This should be explored with the URC and QA staff member. The monitoring team found many QDRRs to be missing from the records (see section N). The same was not identified by these monthly audits. The URC should ensure that this aspect of the active record audit is being done correctly. There were some graphic summaries of some data. This needs to be improved. Currently, at the end of each month's recommendation spreadsheet were graphic presentations of that month's data. This was fine, but insufficient. Instead, there should line graphs that show, month to month: • The total average ratings across all reviews. • The average number of recommendations per review. • The average number of recommendations that were not corrected as of the cut off date (i.e., two months). In addition, graphs could be created of the above three bullets to provide more detailed information, such as, but not limited to the following, that is, by: • Home secretary • Home • Discipline department • Type of document/section of the unified record. Also, now that data were being collected, the URC (along with the QA department) should	

#	Provision	Assessment of Status	Compliance
		review these data to identify unresolved issues, analyze the data in more depth to identify specific issues or departments requiring more attention, and develop corrective actions, as appropriate, to address them.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During the previous review, and in the previous monitoring report, the monitoring team detailed the activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The facility showed progress in this provision by taking first steps to assess, and possibly address, the six activities in this provision item. The URC revised the V4 tool and in it included items directly relevant to some of these six activities (#1, #3, #4, and #5). Then she included some of these results in her data calculation for scoring the overall V3 audit, and, further, she included some of this information in her QA monthly benchmark meeting data and in the one QA report since the last onsite review (e.g., suggestions from the V4 interviews). This was all good to see and showed that she was making progress. The next step is for the URC to indicate how she decided the yes/no rating for these items on the V4 tool (i.e., criteria). For item #6, the URC wisely took advantage of the facility's section F self-monitoring activities and self-monitoring tool. This tool recorded whether the active record was present and whether it was used if needed at the annual ISP meeting. Below, the six areas of this provision item are again presented, with some comments regarding SGSSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> SGSSLC was self-assessing this as part of the monthly audit. It was not clear, however, how a determination was made by the auditor. The monitoring team observed that: • Direct support staff reported that the individual notebooks were easy to use and readily accessible. • Individual notebooks, however, were locked in the office in most cases. It was unclear if DSP staff had easy access to them. • There was some indication that active records sometimes remained in the provider meeting room after the daily 4:30 meeting. For example, dental staff were reported that they had trouble accessing records due to this. A meeting with the ADOP and unit directors on 11/12/12 indicated that this was going to be addressed. • Records were not available during some of the psychiatry clinics that delayed	Noncompliance

#	Provision	Assessment of Status	Compliance
		the record review by the IDT and psychiatrist. Staff reported that records were left overnight in another building, where clinics were conducted, instead of being returned to the designated record room. • Pharmacy department staff reported that records were often not available to complete QDRRs. Many QDRRs had a notation that the record was not available. • Complete records and/or portions of records were often missing, and their whereabouts unknown, during all times of day, but especially during morning and afternoon hours. This resulted in delayed follow-up to physicians' orders and/or missed information. For example, during the onsite review, the monitoring team observed the following scenario: o At approximately 5:00-5:30 pm, an SGSSLC physician came to the unit to see an individual who complained of not feeling well. At approximately 5:45 pm, when the nurse on-duty attempted to retrieve the individual's record to read the physician's assessment and review the physician's orders, she was unable to locate the record. After a search of the area where the records were stored, the nurse on-duty consulted with the Campus RN, who said that he would follow-up. It took the Campus RN, and other untold facility personnel, to the next day to find out what happened to the individual's record and why it was not on the unit at the time of the individual's physician's visit. • There were a number of late entries noted in the IPNs by habilitation therapists due to difficulties accessing the individual records. • ISP and risk plans were accessible to DSPs in individual notebooks. <u>2. Data are filed in the record timely and accurately</u> SGSSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be used to satisfy this requirement, too. • The monitoring team's review of a sample of unified records and the monthly unified record audits indicated that some documents were not filed in a timely or accurate manner. • There were missing Interdisciplinary Risk Rating Forms and pages of forms, missing Risk Action Plans and pages of plans, missing annual nutrition assessments, many missing quarterly comprehensive nursing assessments, and many missing ACPs and HMPs. • Medical provider minutes had documentation of untimely filing of a consultation that resulted in the facility medical staff not having the most up to date information. • Habilitation therapies documentation of interventions was completed in the IPNs for ready access by all team members. A new documentation form was	

#	Provision	Assessment of Status	Compliance
		implemented to reflect treatment sessions and filed in the Habilitation Therapy tab. This was acceptable if there was a routine review of these with a summary note written on a monthly basis to identify progress toward specific measurable goals and the effectiveness of the treatment, appropriateness of continuing, need for changes in the treatment plan or discharge. • Although ISP and risk plans were accessible to DSPs in individual notebooks, 38 updated ISPs were not filed within the required 30 days, thus delaying the implementation of plans. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> SGSSLC was also self-assessing this as part of the monthly audit. It was not clear, however, how a determination was made by the auditor. The monitoring team observed that: • Data collection reliability needed improvement. See K4. • There were blank/missing entries in 20 of the 21 individuals' MARs, including blank entries for vital signs, weekly weights, etc. • Habilitation therapy data collected was more predominately related to implementation of interventions, rather than specific data related to measurable outcomes outlined in the goals and objectives. • The data regarding results of the DISCUS and MOSES were not obtained/documented timely. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> SGSSLC was also self-assessing this as part of the monthly audit. It was not clear, however, how a determination was made by the auditor. Specific criteria for a yes/no rating should be determined. The monitoring team observed that: • Medical provider entries were very good and legible, making the entries usable to the reader. • One of the medical staff and all of the dental department wrote their entries electronically. • The psychiatrist used the IPNs, QPMRs, and Appendix B outline regarding documentation of psychiatric information for care and treatment of the individual. • There continued to be little evidence that nurses' consistently reviewed individuals' records to make care/treatment/training decisions to address acute changes in individuals' health status. Rather, nurses' were much more likely to make care, treatment, and training decisions based upon reports from direct care staff members and their observations/descriptions of changes in individuals' health status.	

#	Provision	Assessment of Status	Compliance
		• The IPNs failed to reveal that nurses consistently incorporated a review of the individual's history and/or prior illnesses and /or injuries and prior assessments as part of their evaluation and/or when they made care, treatment, and training decisions. • IPN entries made by Habilitation Therapies described actions taken by clinicians, findings from effectiveness monitoring, and documentation related to direct therapy. The documentation of interventions was not consistent, or either the provision of these services was not. The IPNs were incomplete in that they presented a description of the interventions, but little analysis and justification to continue, modify, or terminate. Little documentation was noted as to specific progress toward measurable treatment goals. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • Interviews were conducted as part of each monthly unified record audit. Good information was provided by the interviewees regarding their use of the unified record. • Information was summarized in the monthly QA benchmark meeting reports and in the one QA report completed for section V since the last onsite review. • The psychiatrists and the IDT referenced numerous documents from the unified record during the psychiatric clinics observed. The other disciplines inclusive of nursing summarized findings, such as laboratory work that was obtained from the unified record. • When a random sample of nurses were asked about how they used the individuals' record to make care/treatment/training decisions, they reported that during their quarterly and annual assessments they review the individuals' records to make decisions regarding their assessments, diagnoses, and risk ratings. <u>6. Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions</u> The URC was using data from the facility's section F self-monitoring tool. This was a good idea. Data reported that the active record was available and was used in most of these meetings. The monitoring team found the following: • The active record was available at the annual ISP for Individual #48. The RN case manager used the active record to read lab results aloud to the IDT. • At Individual #127's annual ISP meeting, his record was present and used to obtain health information that was pertinent and relevant to the discussion of the individuals' health risks/health risk ratings. • The psychiatric staff did not routinely have the medical record available in	

#	Provision	Assessment of Status	Compliance
		meetings during the discussion of the individual's care. The meetings included the polypharmacy committee and the medication review committee where the care of individuals, such as the prescription of polypharmacy and/or chemical restraints for identified individuals, was presented. • During the PNMT meeting there were individual records were available and used throughout the meeting.	

Recommendations:

1. Ensure records are available, including ensuring they are not left overnight locked in meeting rooms (V1, V4).
2. Consider moving supervision of the home secretaries from the unit directors to the URC (V1).
3. Examine the inter-rater agreement scores for the home secretary audits (V1).
4. Include the medical consultations in the audits done by the home secretaries (V1).
5. When revising the table of contents and guidelines, be sure to check with state office before deleting or removing any items (V1).
6. Continue to address missing, misfiled, out of date, and/or un-thinned (not yet purged) documents in the active record, legibility and correctness of handwritten entries, and missing SAP entries (V1).
7. Examine the actual availability of individual notebooks for DSP staff, given that the individual notebooks were often observed to be locked in the office during the onsite review. It may be that the current system works just fine. This recommendation is to examine this and to make changes only if necessary (V1).
8. All logs, binders, and data sheets not kept in the individual notebook should be part of any review or audit of the individual notebook (V1, V3).
9. Document, in the master record, the IDT's response to any items that are missing and unobtainable in the master record (V1).
10. Create state policies for all remaining provisions of the Settlement Agreement (V2).
11. Consider the bulleted suggestions in this report regarding the state and facility policies spreadsheet that is managed by the QA director (V2).
12. Modify the audit scoring so that it accurately reflects the absence of falsification of data (V3).
13. When the URC, during her audit, removes a document that should not have been thinned from the record, but wasn't, consider counting these in the total number of recommendations (V3).

14. Examine the differences in the inter-rater scores between the QA department and the URC (V3).

15. Ensure that the QDRR review in the active record audit is being done correctly (V3).

16. Improve the way graphs of recordkeeping activities are made and kept (V3).

17. Review recordkeeping data to identify unresolved issues, analyze the data in more depth to identify specific issues or departments requiring more attention, and develop corrective actions, as appropriate, to address them.

18. Ensure records are brought to psychiatry clinics (V4).

19. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the six areas highlighted with underlined headings in section V4 (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
AAUD	Administrative Assistant Unit Director
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABX	Antibiotics
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ADA	American Dental Association
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AOD	Administrator On Duty
AP	Alleged Perpetrator
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations

APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
AROM	Active Range of Motion
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BC	Board Certified
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLE	Bilateral/Both Lower Extremities
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee
BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System

CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEA	Carcinoembryonic antigen
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CPT	Certified Pharmacy Technician
CPT	Certified Psychiatric Technician
CR	Controlled Release

CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery
DERST	Dental Education Rehearsal Simulation Training
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNP	Doctor of Nursing Practice
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRM	Daily Review Meeting
DRR	Drug Regimen Review
DSHS	Texas Department of State Health Services
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis

DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
ECG	Electrocardiogram
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENE	Essential Nonessential
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
ERC	Employee Reassignment Center
FAAA	Fellow, American Academy of Audiology
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder

GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
GI	Gastrointestinal
GIFT	General Integrated Functional Training
GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HOBE	Head of Bed Evaluation
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICA	Intense Care Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ID	Intellectually Disabled

IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
IHCP	Integrated Health Care Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOC	Level of Consciousness
LOD	Living Options Discussion
LOI	Level of Involvement
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center

LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education
Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MHA	Masters, Healthcare Administration
MI	Myocardial Infarction
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOT	Masters, Occupational Therapy
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science
MSN	Master of Science, Nursing
MPT	Masters, Physical Therapy
MSPT	Master of Science, Physical Therapy

MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NIELM	Negative for Intraepithelial Lesion or Malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
OIG	Office of Inspector General
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
PA	Physician Assistant
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PAI	Provision Action Information
PALS	Positive Adaptive Living Survey

PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PDR	Physicians Desk Reference
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
PO	By Mouth (per os)
POI	Plan of Improvement
POX	Pulse Oximetry
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Personal Skills Assessment
PSA	Prostate Specific Antigen

PSAS	Physical and Sexual Abuse Survivor
PSI	Preferences and Strength Inventory
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RML	Right Middle Lobe
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out
ROM	Range of Motion
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic

RX	Prescription
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIDT	Special Interdisciplinary Team
SIG	Signature
SIS	Second Injury Syndrome
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Speech Therapy
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAC	Texas Administrative Code
TAR	Treatment Administration Record
TB	Tuberculosis
TCA	Texas Code Annotated
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline

TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSHA	Texas Speech and Hearing Association
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old